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Assessing Barriers to Mental Healthcare Interventions for Deaf People in Ghana

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Abstract

While mental health issues are increasingly gaining attention in Ghana, little is known about the situation among deaf people. This study assessed the mental health care needs of deaf people in Ghana. A descriptive design, consisting of interviews and focus group discussions, was used to collect data from 97 participants. Findings indicated that participants had limited knowledge on mental health issues. Mental health stigma, inaccessible mental health information and exclusion from mental health programmes were the major barriers hindering access to mental health care services. This study bridges the knowledge gap and provides evidence for the implementation of deaf-friendly services.

Keywords

Access, Barriers, Deaf People, Mental Health, Caregivers, Civil Society Organizations

1. Introduction

Over the past decades, mental health has received significant attention at both national and global levels because it has been recognized as a major public health issue. Mental illness affects millions of people, and its effects can be devastating, with the overall wellbeing of persons with mental health conditions and their families can be greatly affected [1]. Mental health conditions are a major cause of disability and death in both youth and adults [2]. Cases of mental health conditions are also rising globally, and efforts at mitigating the situation appear not to be yielding the expected outcomes [3]. It is estimated that mental health problems constitute 12% of the worldwide burden of disease and this was predicted to increase to 15% by 2020 [4]. It has also been predicted that 40,000 people are expected to die from various mental health conditions such as unipolar and bipolar depression, schizophrenia, and post-traumatic stress disorder from 2002 to 2030 [5]. However, a large portion of the global population, especially disadvantaged groups, in need of mental health service do not receive them. This study investigated the barriers deaf people in Ghana encounter accessing mental health care.

1.1. Mental Health and Persons with Disabilities

Several studies have confirmed that worldwide, persons with disabilities are at higher risk of mental health issues than the general population, but their mental health needs are often ignored or misunderstood [6]. The WHO report, for example, stated that, globally, an estimated 17.4 million adults with disabilities have frequently reported having mental illness, which is about 4.6 times higher than those without disabilities. Similarly, Glazier, R. and Kling, N., [7] reported that the overall prevalence of substance abuse among persons with disabilities was higher (40%) compared to their counterparts without disabilities (34%). In the United Kingdom, Harris, J. and Lord, C., [8] discovered a higher risk of mental health conditions among children aged 11 years with visual impairments than sighted children of the same age. For example, depression was found to be higher among children with visual impairment than in their sighted peers [9].

Deaf people are more likely to experience mental health conditions than the hearing population, both with and without disabilities [10] reported that deaf people experience mental health conditions at about two times the rate in the general population and have serious challenges accessing needed mental health services. It has also been reported that about 40% of deaf children have mental health condition compared to 25% in hearing children [11] [12] [13] [14] [15]. The prevalence of anxiety, schizophrenia, depression, phobias and psychoses are for example, very common among deaf people. A Norwegian study which assessed symptoms of depression and anxiety in the general population, confirmed this and indicated that deaf respondents reported more symptoms than their hearing counterparts [16].

Several factors are responsible for deaf people's poorer mental health status compared with the hearing population. Deafness exposes deaf people to extreme social, emotional, and cognitive challenges in a hearing-dominated world. For many people, deafness is associated with social exclusion, discrimination, reduced educational attainment and limited employment opportunities. Deaf people also struggle with stigma associated with hearing loss, prejudice, and communication issues daily [17]. These are predisposing factors to various forms of mental health conditions. However, deaf people are underserved in mental healthcare programmes and psychiatric conditions among deaf people are frequently under-diagnosed [13]. Mental health care interventions and assessment procedures for the general population are generally not suitable for deaf people. For example, standardized tests and mental health measures designed for hearing people have been found to be invalid when used with deaf people [18]. Communication difficulties with healthcare providers compound the situation for the deaf community. Studies have found that lip-reading is inadequate and skilled interpreters are often scarce [13] and many deaf people fear being misdiagnosed because they are unable to communicate effectively with health workers [13]. While ineffective communication limit access, it also increases the risk of deaf people developing mental health conditions [19].

Interpreters perform an important role by assisting deaf people to negotiate communication barriers in the healthcare setting. Their presence is therefore vital to bridging the communication gap. However, the use of intermediaries, such as interpreters, in the healthcare setting, especially in mental health, is challenging. For example, sign language interpreters may have little knowledge negotiating the cultural and linguistic nuances about the deaf community, which may adversely affect interpretation [20] [21]. There are also concerns about the privacy of deaf patients seeking mental health care, as the presence of an intermediary, either an interpreter or a family member, could compel deaf patients to withhold vital information from their health care provider [22]. This is especially true in Ghana, where there are very few professional sign language interpreters, where most deaf people and interpreters are constrained by limited proficiency in English [23] and where there is a lack of expansive vocabulary in Ghana Sign Language (GhSL). Thus, while data on deaf people with mental health conditions in Ghana is scanty, the situation among them is unlikely to be different from what exist elsewhere. Hence, deaf people being able to talk directly to the healthcare provider would be ideal.

1.2. Policy, Legal and Contextual Issues on Mental Health Care in Ghana

Ghana has made some progress in mental health interventions, particularly in terms of legal and policy frameworks. The government has, for example, formulated a Mental Health Policy and passed the Ghana Mental Health Act (846) to regulate mental healthcare in the country. The current National Mental Health Policy (2019-2030) aligns with the national and international human rights standards as well as best practices in global mental healthcare. Prior to the enactment of the Mental Health Act, the Persons with Disability Act (175) was passed in 2006 and the United Nations Convention on the Rights of Persons with Disabilities (CRPD) ratified in 2012. These legal instruments have ramped up disability activism in Ghana and leveraged issues concerning persons with disabilities, including those with mental health conditions.

It is worth noting that mental health policies and legislations are important for promoting equitable access to healthcare. Healthcare policies, for example, establish regulatory frameworks that guide decision-making on health, resource allocation, and outreach programmes [24]. In view of this, the UNCRPD emphasizes the need for a national health policy to ensure persons with disabilities have equal access to health care services, including those on mental health care [3].

However, important mental health policies and laws in Ghana such as the Mental Health Act 846 [25], do not specifically target persons with disabilities as a "special" group who may need special attention. Even though deaf people are at a high risk of mental health conditions and there is a tendency to exclude them from mental health services. Deaf people are also not identified as a special group [23]. This implies that policies and guidelines formulated on the basis of these policies and laws, are not likely to address the concerns of persons with disabilities, and for that matter, deaf people. Therefore, deaf people with mental health conditions are likely to face challenges accessing mental health care services. Thus, despite the gain's government is making in improving mental health care, including nationwide awareness on mental health issues, these may not yield the needed impact of reducing stigma and discrimination, without targeting deaf people, who are one of the most marginalized groups in Ghana [23].

Several studies have been conducted to identify gaps in mental health care delivery and specific needs in order to increase access to mental health services. Examples of these studies are reported in World Health Organization WHO Report on the State of Mental Healthcare System in Ghana [6] and the WHO Country Office Ghana Annual Report [26] report from these studies, however, did not include data on deaf persons and so their needs are invisible to policy-making. This calls for the need to target this population.

The paper was culled from a large study which assessed that knowledge of deaf people on mental health issues and barriers they encounter when accessing mental health services. Specifically, the paper assessed the sources of information on mental health issues among deaf people, ascertained the use of mental health services among deaf people, and examined the barriers they face in accessing mental health services.

2. Methodology

2.1. Design

The study design was descriptive and utilized a mixed methods approach. However, since this paper focuses on only findings on the qualitative component of the study, the qualitative data collection methods are described. According to Aggarwal, R. and Ranganathan, P., [27], a descriptive design enabled the researchers to present participants' views as presented by them without manipulation. Descriptive studies are frequently used when the researchers' intention is to provide straightforward descriptions of experiences and perceptions of participants [28], since this design is particularly important for issues that little is known about [28]. It is suitable for our study because of lack of knowledge around mental health conditions among deaf people in Ghana.

2.2. Participants, Sample and Sampling Techniques

The study was conducted in four regions of Ghana. They are Northern, Central, Upper West, and Greater Accra Regions. As contained in **Table 1**, the participants included deaf people with or without mental health conditions, representatives of CSOs, mental health professionals, and caregivers.

In the case of deaf people with health conditions, only deaf people who were diagnosed by certified medical officers, and were fairly able to articulate their views, were included in the study. Lack of formal education was an exclusion criterion for all deaf participants because formal education is required for one to learn and use the GhSL, which was the language used to collect data from deaf people. Therefore, the basis of exclusion for some deaf participants was lack of formal education and knowledge in the GhSL. They were excluded because communicating with deaf participant in GhSL would have been extremely time and resource intensive and would have required working through intermediaries (usually family members). This would have raised concerns around issues of confidentiality and informed consent.

Participants must also be at least not below 20 years. Thus, participants who were 20 years and above, fluent in GhSL, and permanent residents in the selected project regions, were those included in the study.

Purposive sampling technique was used to select all the participants for the qualitative component of the study. Recruitment was done at deaf centres, during the monthly regional and district meetings of GNAD members and in the deaf churches. The regional and district leaders of GNAD and our deaf field assistants assisted with the recruitment of the participants. Letters explaining the purpose of the study and eligibility criteria were sent to all the regional and district leaders on the project regions, who informed their members of the intended study.

Dates were scheduled with members for each project region. At each recruitment location on the scheduled date, participants were screened for eligibility based on our eligibility criteria. Those who qualified were taken through the informed consent process; all participants signed the informed consent before participating in the study. The hearing participants (representatives of CSOs and healthcare workers) were selected by their respective organizations, using our

Table 1. Summary of participants in the study.

No	*Participants*	*Method*	*No*
1	Deaf persons without mental health conditions	Focus groups	80
2	Persons with mental health conditions	Interviews	8
3	Caregivers	Interviews	11
4	CSOs	Interviews	8
5	Health workers	Interviews	12
	Total		**111**

eligibility criteria, which included being familiar with or having worked with deaf people in the area of mental health. The caregivers were either biological parents or relatives of participants with mental health conditions who were recruited into the study

2.3. Recruitment of Field Assistants

Twelve field assistants were recruited and trained to assist with the data collection. The field assistants were made up of eight deaf graduates, who worked with deaf participants, and four hearing persons who worked with the hearing participants. All the field assistants were fluent in Ghanaian Sign Language, had at least a diploma and above at the time they were recruited and also had history of working with deaf people in different capacities. Each project region had three field assistants (two deaf persons and one hearing person), who worked with participants in the region. The reason for choosing field assistants from each region was to fast-track the data collection and to ensure easy follow-ups. A one-day face-to-face training workshop was organized to train the deaf field assistants; the hearing assistants were trained virtually.

2.4. Data Collection Process

One-on-one interviews and focus group discussions were used for the data collection. Both focus group and interview guides were developed by the researcher using information from the literature on previous studies on deaf people in Ghana (e.g. Author), the researchers' experiences as community members, and interacting with some key leaders of the deaf community and mental health workers. Both the interview and focus group guides contained information on the sources of information on mental health issues for deaf people in Ghana, mental health support services, challenges deaf people encounter seeking mental health services, participants' perception of mental health stigma, mental health stigma among deaf people, and how this affected access to mental healthcare for deaf people.

Four Focus Group Discussions (FGDs), one in each of the four regions, were conducted, with each FGDs having 10 deaf participants. The FGDs were conducted by deaf field assistants in the GSL. All the FGDs were video recorded, with permission from the participants. Ground rules were set for the group discussions to ensure that no one participant dominated the discussions and to prevent intimidation by other participants. This facilitated equal participation and respect for each other's views. Also, the research team debriefed to ensure that the interactions went well and how to improve on successive interactions. The FGDs were conducted at the usual places where deaf people have their meetings, such as deaf centers, and regional association offices. These places were considered convenient for deaf participants. Each interview lasted about 50 minutes, whereas the duration of the focus groups was between one hour and one hour 30 minutes.

One on one interviews were conducted with eight deaf persons with mental health conditions, 31 key informants, made up of eight representatives of CSOs, 12 representatives from the Ghana Health Services (regional health directors or their representatives, regional mental health coordinators, nurses who worked at the out-patients department of mental health units), and 11 caregivers. All the key informants were hearing people whose responses complemented data from the deaf participants and also helped to verify some responses of the deaf participants. Interviews and FGDs with the hearing participants were conducted by hearing field assistants in the English language and audio recorded, whiles interviews with the deaf participants were conducted by deaf field assistants in GhSL and video-recorded. Interviews were conducted at location convenient for participants, such as offices, homes, and deaf centres.

2.5. Data Analysis

Thematic analysis was used to analyse the data. The analysis involves transcribing both the video and audio recordings by six field assistants and the principal investigator into word format. The transcription was done in pairs. One pair of hearing field assistants transcribed the voice recordings, whiles two pairs of deaf field assistants transcribed the video recordings. The principal investigator supervised the process. Each pair listened/viewed the recordings assigned to them several times and then transcribe recordings into word format.

The field assistants and the principal investigator then read through all the transcripts to address any inconsistencies in the transcription. The transcripts were carefully read through again, to get familiar with the data, noting significant statements on the left margins of the transcripts. The data were then coded which involved marking relevant sections of the text using phrases or sentences. These were later shortened into meaningful codes that described specific issues raised by the participants.

Pattern among the codes were sorted out and themes developed out of them. These themes were condensed codes that provided overview of the main points and common meanings that were repeated throughout the data. The themes that emerged were redefined to represent exactly what each participant described in the text and figuring out how they help to understand the responses. The final themes were then listed on a sheet of paper and grouped together according to the objectives of the study. Supported quotations were then assigned to each of the themes.

2.6. Ethical Consideration

Approval to conduct the study was received from the Ethical Review Committee (ERC) of the Ghana Health Services. In compliance with ethical principles of ERC, approval was obtained from the four project Regional Directorates of the Ghana Health Services before the study was conducted. Informed consent was sought from all participants. The participants were informed of the purpose of the study, duration of the interview or focus group discussions, their right to voluntary participate, and their right to withhold information they deemed confidential. Participants were also informed that they were not obliged to answer every question and they were free to withdraw at any time from the study; their decision not to participate would not adversely affect their relationship with the GNAD. The authors report there are no competing interests to declare.

3. Findings

3.1. Socio-Demographic Characteristics of Study Participants

Of the 111 participants, the age group that had the highest representation (44.3%) was those in the 30 and 40 years' bracket. A little over half (51.9%) were Christians, almost three-quarters (58.2%) had basic education, and 43.60% of the male were single compared to 40% of females. Although, a large proportion (60.8%) of the participants were employees, a large percentage of these were likely to be health workers Also, male participants were more likely to be self-employed than (38.5%) female respondents (20%). (See Table 2 below)

Table 2. Socio-demographic characteristics of participants.

Variables	Male		Female		Total	
	n = 39	%	n = 40	%	n = 79	%
Age group						
15 - 29	6	15.4	4	10	10	12.7
30 - 40	14	35.9	21	52.5	35	44.3
41 - 60	10	25.6	11	27.5	21	26.6
Above 60	9	23.1	4	10	13	16.5
Religion						
Christian	15	38.5	26	65	41	51.9
Muslim	18	46.2	14	35	32	40.5
Others	6	15.4	0	0	6	7.6
Educational Level						
Basic education	21	53.8	25	62.5	46	58.2
Secondary	11	28.2	6	15	17	21.5
Tertiary	7	17.9	9	22.5	16	20.3
Marital Status						
Married	13	33.3	15	37.5	28	35.4
Single	17	43.6	16	40	33	41.8
Divorced	2	5.1	1	2.5	3	3.8
Widowed	3	7.7	2	5	5	6.3
Employment						
Employee	21	53.8	27	67.5	48	60.8
Self-employed	15	38.5	8	20	23	29.1
Unemployed	2	5.1	1	2.5	3	3.8

3.2. Access to Mental Health Services

The findings showed mental health interventions were not reaching deaf people. They were either not targeted in mental health programmes or the services were not accessible to them. For example, some deaf people, including those with mental health conditions, were not aware of the available professional support services in their respective regions. Most of the participants with mental health conditions revealed that they did not attend medical reviews and did not receive treatment or rehabilitation services from any hospital or rehabilitation centre. Due to this, participants were unable to comment on the effectiveness of mental health treatments and often they could not tell what kind of mental health condition they had. For example, participants (Participant 1, Accra), with mental health conditions said, "I cannot tell the effectiveness of the treatment since I had not received any before". Similarly, another participant also had this to say; "I have not been to the hospital for a long time, so I cannot talk much about them [effectiveness of medication], but I am sure others [deaf people with mental health conditions] too will not be able to say anything about the drugs." (Participant 2, Wa)

3.3. Accessing Mental Health Information

On the sources of information on mental health issues, participants mentioned both traditional and new media, specifically social media platforms such as Facebook and WhatsApp and television stations. They also identified peers, collaborators and other stakeholders such as teachers, GNAD, friends, and family members. Of these sources, information from television and family members were considered the least accessible while the most accessible sources were the internet and friends. However, although participants complained of the lack of sign language interpreters on the television, it provided visual information on the conditions.

For example, a participant from Cape Coast, with a mental health condition described information from the television stations as "…not being very accessible because of absence of interpreters during most of the programmes" (Participant 2, Cape Coast). Another participant agreed with this view adding "…information on TV is not accessible, I used the newspaper at times but I can't read them well" (Participant 2, Accra). Another participant further elaborated in the quote below:

> The family source is not accessible because the family use local sign languages, so not everything can be understood. Information from deaf friends is accessible because we use the same sign language which helps us to understand than family but TV and newspapers are hard to understand (Participant 3, Accra)

Most of the participants therefore said they were not satisfied with the information they received from the television and commonly used sources: "I am not satisfied with the information I receive from the TV and important sources because it is not enough" (Participant 1, Wa). They suggested that, "It would be easier if the information on TV has interpreter inserts and subtitles so deaf people can easily access it" (Participant 1, Accra).

An important finding is that health professionals were not mentioned as a source of information on mental health conditions probably because of communication barriers and/or/the exclusion of deaf people from mental health programmes.

3.4. Barriers to Mental Health Services

3.4.1. Communication Barriers

Communication was reported as the greatest barrier facing deaf people seeking mental health care. All the deaf participants with and without mental health conditions reported communication as the most serious challenge. For example, al the FGD participants said health care providers did not understand sign language and since there were no sign language interpreters in the hospitals, including psychiatric hospitals, communication with services providers would be difficult.

A major consequence of the communication barrier is ineffective interaction between health professionals and deaf people with mental health conditions, which affected treatment and care for deaf people.

> "The major challenge is the language barrier. Some of the deaf can't use the sign language very well so it poses a challenge communicating with them. The families also do not give them full support as in encouraging them to return to the facility for further treatment after the first visit" (Participant 1, Wa).
>
> "I was taken to Mamprobi polyclinic. I was not given any referral. There was no specialist treatment. Even if there was, I cannot tell since I went with my mother or sister anytime and there was no interpreter, so I do not know what sort of conversation went on at the hospital" (Participant 2, Accra).

The CSOs confirmed that communication is a key barrier to working with deaf people. According to the CSOs, majority of the psychiatric hospitals that they had worked with to provide treatment for deaf people did not have sign language interpreters nor were the staff able to communicate with deaf patients. This situation, according to CSOs, hindered communication during consultations and ultimately, treatment for deaf people. Two CSOs from the Upper West Region and Greater Accra respectively expressed this in the following words: "Deaf people are normal human beings and can easily seek mental health services at any facility or organisation. Their only challenge will be how the service provider will communicate with them if there is no sign language interpreter available." Another participant from a CSO said "it all boils down to communication challenges because currently, we do not know of any sign language interpreters in any of the psychiatric hospitals we have worked with and that is something that will be a major challenge for us working with deaf people."

The CSOs thought communication barriers may have serious negative implications on the treatment of deaf people with mental health conditions because:

> Right from diagnosis, history taking is very key and if the deaf person is not able to communicate to the mental health officer or the psychiatrist about the history, it becomes a limitation and there will be a wrong diagnosis. And if he is on medication and he is not responding very well or has side effects, it will be difficult communicating to the caregiver or the mental health officer (CSO 2, Accra).

Another effect of the communication barrier is undue delay experienced by deaf people with mental health conditions seeking care. A FGD participant from Cape Coast stated that "when health workers identify that the patient is also deaf, they then start to search for interpreters. This takes a lot of time and results in delays attending to the patient." Another participant from Accra said once health workers found that the patient is a deaf person, "they will ask him/her to wait, wait, wait because they can't communicate and then soon forget about the deaf patient…" (Participant 4, Accra). Also, some of them would "pretend and act as if they are too busy to attend to the person with mental health condition" (Participant 6, Accra).

However, health workers reported another observation relating to communication. They asserted that the communication barrier could not entirely be attributed to health workers' inability to use the sign language, but sometimes emanated from deaf people themselves, this occurred especially among those who had no formal education and could not use the sign language. A health worker from the Upper West Region, for example, expressed the above challenge in the following statement: "the major challenge is the language barrier. Some of the deaf can't use the sign language very well so it poses a challenge communicating with them. (Participant 1, Wa).

3.4.2. Low Mental Health Literacy

Related to communication barriers is inadequate mental health literacy among deaf people. This factor was identified by the CSOs who thought that mental health literacy among deaf people was likely to be low because of communication issues. This, according to the CSOs, is caused by the lack of information in accessible formats such as sign language and exclusion of deaf people from mental health education programmes. For instance, a participant (CSO 1, Upper West) described the mental health literacy among deaf people as "very, very, low." He attributed this to communication challenges, as it is usually difficult to communicate with them (deaf people) and some of the things in writings, many cannot read. Confirming this, another person indicated that, "it's been difficult for deaf people to acquire mental health literacy because increasing their literacy would require getting professional sign language interpreters to interpret the knowledge on mental health conditions and that has been difficult to get because there are few in Ghana (Accra, CSO, 2).

3.4.3. Poverty and Economic Hardship

The majority of FGD participants noted that poverty and economic hardship were also key barriers to mental health care services for deaf people. Deaf people generally have limited access to employment. The situation is worse for those with mental health conditions. After acquiring the condition, businesses of those who are self-employed collapsed, whiles those who were in paid jobs were either laid off or exploited. Thus, most of the FGDs participants described the livelihood of deaf people with mental health conditions as "poor" because their businesses collapsed due to their condition and stigma. As confirmed by participant 4, the economic conditions of deaf people with mental health conditions "become destroyed because their business often collapsed as customers no longer prefer to patronize their wares" (participant 4, Accra). Those who were employed "have to quit their employment or they are fired" (participant 5 Accra). Since mental health care in Ghana is not free, accessible mental health care will be difficult for deaf people who did not have secured source of funding.

Undoubtedly, deaf people with mental health conditions would find it difficult to utilize mental health services without financial support, for example from family members. A participant from the Greater Accra Region, indicated that, "they [deaf people with mental health conditions] are unable to care for themselves and those who depend on them too would suffer in the long run and cannot care for them" (Participant 1, Accra). Because they rarely engage in economic activities, "it affects their ability to fend for themselves and since many people do not want to be associated with them, their livelihood is greatly affected the ability to use the hospital affected (participant 1, Wa).

Although some family members were supportive, according to healthcare providers, many of them were unsupportive and did not send their relatives for treatment. According to a participant, many of the families "…supported their deaf children but some don't have time for them (participant 6, Wa). Another participant agreed and explained that, "some families are supportive as they lead them to [health] facilities for medications and reviews whiles many others do not give maximum support to the deaf (Participant 1, Wa).

Poverty is compounded by the high cost of treatment. Some of the participants lamented over the high cost of medical treatment, which they said, "affected access to mental health care for deaf people" (Participant 3, Wa). Although caregivers reported that they got some relief by subscribing onto the national health insurance scheme (NHIS), the amount was meagre and the scheme did not cover all services and drugs. For example, a caregiver said that they registered for the insurance so anytime "we visited the hospital, part of the expenses is catered for by insurance…we however buy the medicines that are not at the facility, which is quite expensive (Caregiver 2, Wa).

3.4.4. Negative Attitudes

Attitude of family members, health care providers and the general public also emerged as major barriers to mental healthcare services to deaf people. Both participants with and without mental health conditions reported negative attitude of family members as a barrier mental health healthcare. Negative attitude of family members, including ill-treatments in the form of denial of food and shelter, locked up (hiding them) in the house suggest such people are unlikely to receive any medical attention. As a deaf participant from Accra noted, "…they [deaf people with mental health conditions] are not given good place or shelter/bed and served poor foods and sometimes locked up" by their family members. A participant in Wa confirmed this and said some family members "…abandon deaf people with mental health conditions at prayer camps. The mount a lot of pressure on mental health patients who are deaf and hide them in the house and wish nobody should know that they have mental health patient" (participant 1, Wa).

Responses from participants with mental health conditions suggest that they rarely utilize mental health services. For example, a participant said he could not comment on the attitude of healthcare workers because he "…had not been to the hospital for a long time (Participant 3, Cape Coast). A similar comment was made by another deaf participant with mental health condition, who said "I cannot talk much about their attitude. I have not been such places [hospital] but I am sure others [deaf people with mental health conditions] too cannot tell because they have not been to the hospital."

Although the caregivers' responses were not straightforward, they were suggestive because they appeared indifferent about their wards' conditions, as exemplified in following comment: "his behaviour doesn't cause me any worry. I am not really worried…well he is cool and does not do anything that brings extra worry to me or cost" (participant 3, Cape Coast). A participant from the Northern Region also said "I do think from time to time, but it has no negative impact on my business though" (participant 1, Northern). Similarly, their children's condition did not affect their financial status, as reported by the following participants: "There is really no financial burden on me in caring for her" (participant 1, Wa); "Apart from his basic needs, there is no financial implication" (participant 2, Wa). However, caregivers said they needed support" because sometimes they [people with mental health conditions] become a burden on their caregiver sit would be better if the government can support the caregivers in any means to care for them" (participant 1, Cape Coast). This is somehow contradictory to their previous responses.

Respondents with mental health conditions also reported that aside their families, attitude of the public including those around them prevented deaf people with mental health conditions from accessing mental health care. The attitude of the public was described by some participants as discriminatory and disrespectful. They "experienced labelling, name calling, looked down when around people and kept away from the public" (participant 2, Accra). A participant described the situation as "worrying" because "the deaf with mental health conditions get more discrimination and ridicule from the public and society show no respect at all to them. This makes them shy and can't go out to do anything like healthcare" (participant 1, Wa). Another participant explained that deaf people with mental health conditions are abandoned by their friends as captured in the following words; "some friends stopped visiting them [people with mental health conditions], and their friendship slowly died because of their condition and can't get any support such as medical care" (participant 2, Accra).

These responses from the deaf participants regarding the attitude of the public towards deaf people with mental health conditions are consistent with those of CSOs and healthcare workers. According to the CSOs, for example, some members of society associate mental health conditions with curses, leading to them shunning people with mental health conditions. This attitude from the public affected treatment and caused family members to withdraw from the treatment process. A participant elaborated on the situation in the quotes below:

> In our communities, the negative attitude is too much. It's not easy. Sometimes you visit clients in their homes, and they tell you how the community makes it difficult for them. Some even feel it's a curse and we are doing our best to educate the public (participant 2, Wa).

Besides the communication issues, the general attitude of healthcare workers also emerged as an important factor hindering access to care. Although the majority of the healthcare professionals described their attitude towards deaf people with mental health conditions as good and receptive, there were reservations by some deaf participants and some healthcare workers. A section of the participants claimed that health care workers were not willing to provide care for deaf people with mental health conditions, especially those who are poor. They see "deaf people as poor and can't pay for quality care" (Tamale 3). This was confirmed by another participant, who said: "depending on the situation of the deaf person. If the family is well to do, they [health care workers] will provide care but if not well to do healthcare workers generally don't want to care for them" (Tamale, 2).

Healthcare workers associated good attitudes to their training, which requires them to provide treatment to everyone irrespective of his or her situation. They are therefore supposed to be "very, very supportive as they are trained to handles all manner of conditions, so they understand and handles them [deaf people with mental health] well" (Tamale 1). The quotations below summarizes the views of healthcare workers.

> "Personally, I have not come across anyone [healthcare worker] who has tried to use a word to malign anyone [deaf person with mental heal condition]. Per our training, I think we should be able to live up to task. We treat people irrespective of race, color or status so I believe, or I am with the conviction that a health worker should be able to live up to the task if not then it means the person has his own prejudiced mindset. But I have not come across anybody doing that to anyone" (Accra 2).

Some healthcare professionals confirmed the negative attitude of their colleagues but blamed the situation on their inability to communicate with deaf people as exemplified in the following quotation: "…the attitude [of health care workers] is somewhat negative because we don't understand them well. Their sign language and all that, is problematic. If we receive one right now, I will find it difficult to interact with them" (Accra, 2).

3.4.5. Mental Health Stigma

Stigma as a barrier to mental healthcare for deaf people was a common theme among all the participants. Participants reported that deaf people with mental health conditions were severely stigmatized. According to the deaf participants, "deaf people with mental health conditions suffer social stigma, which leads to eviction from rental homes, fed with malnourished foods, whipped with no justifiable reason, sometimes forced to tie their legs on wooden materials" (UWR01). Because of mental stigma and associated treatment, "it is not easy to get early treatment for them [deaf people with mental illness], and some are not sent for early treatment because of stigma" (Accra 5). The situation of some deaf people with mental health conditions "deteriorates and "become worse as they are unable to access support or care due to stigma" (Tamale, 2).

In support of the views of the deaf participants, a representative of CSOs indicated that, "mental health stigma is a widespread canker in Ghana where persons with mental illness are labelled, stereotyped, and discriminated on all over" and that "the situation is very bad" (Wa, 2). Because of the stigma, according to another CSO representative, "people distanced themselves from people who are mentally ill for fear that they may contract the mental health condition from them, which affects their treatment" (Northern, 1). This situation could be worse for deaf people with mental health conditions:

> Stigmatization that is the way people or society see persons with disabilities, and it will be a "double tragedy" for deaf people with mental health conditions because you are a deaf person and you have contracted a mental health condition (CSO 1, Accra).

The participant noted further that "most persons with mental health conditions are mostly rejected by society and they are not involved in normal social life. Once deafness is added, it compounds the situation, and most people hate them" (Wa, 1). Another CSO expressed the issue in the following terms; "generally, people with mental health conditions are worse off with attention and if you are someone who is a deaf person and with a mental health condition, this will only mean that the person is worse off within the family. So, there is a general negative attitude towards people with mental health conditions, so if the person is deaf and also, has a mental health condition, then, I would say this attitude will be more negative attitude from families (CSO 2, Accra).

Similarly, caregivers reported that stigmatization affected access to mental health care for deaf people with mental health conditions. Deaf people with mental health conditions were stigmatized because of their "multiple disability" causing some of their children to refuse medical care: "Medication is free under health insurance, but he doesn't allow us to take him there [mental hospital] because of stigma" (participant 2, Wa).

4. Discussion

This paper investigated the barriers deaf people encounter in their attempt to access mental health services in Ghana. Mental health is one of the major public health issues in Ghana and the government of Ghana has adopted a number of strategies to increase access of the general public to mental health services. However, findings from the study suggest that these efforts are not reaching deaf people, especially those who need mental health services. Findings from the study provide insights into the complexity of factors that influence the mental health care seeking behaviour of deaf people in Ghana.

The major barrier deaf people encounter is related to communication. In the health care setting, effective communication is vital as it allows the patient to convey what is happening to him or her to the health care provider. It means that information on health issues should be in accessible formats, preferably in sign language, to enable deaf persons to benefit from health services, programmes, and activities. However, in Ghana, the major sources of information on health issues, including mental health do not incorporate sign language interpretation services. For example, the television programmes are not captioned, nor do they use sign language interpreters. The low reading skill among deaf people would also make it difficult to access information in print formats such as brochures or the internet.

Although participants mentioned the television and social media as their sources of information on mental health issues, these sources are unlikely to be fully accessible to them. The volume of information of varying qualities available to health consumers and the use of complex terminologies in mental health information can make accessing accurate, up-to-date and reliable information on mental health conditions difficult for deaf people. Without accurate information on mental health conditions, mental health literacy among deaf people is likely to be low. This has implications on the treatment and help-seeking behaviour of deaf people with mental health conditions.

Steinberg *et al.*, [21] reported that communication barriers between deaf people and healthcare workers hindered access to quality of care for deaf people, as poor communication makes it difficult for deaf people to clearly describe their condition and follow instructions from health care providers. Because of the complex nature of mental health and its management, effective communication with the health care provides very essential [29]. This is particularly important in the case of deaf persons whose behaviour often complicates their mental health status. However, although using sign language interpreters could break the communication barrier, it could also be problematic as it may breach the privacy of deaf patients. The stigma associated with mental health conditions make this a critical issue and a paradox that should not be overlooked when providing mental health care for deaf people. Similar observations were made by the Author in sexual and reproductive health studies among deaf people in Ghana, suggesting that this situation is pervasive.

Although there were concerns about possible misdiagnoses due to miscommunication, there are no official records of such incidents. This can however not be ruled out completely. The lack of evidence on misdiagnoses could probably be due to the inability of deaf people to communicate any side effects or challenges to their healthcare provider leading to underreporting. This finding is consistent with two early findings in the United States and Australia. In the case of Australia, Webb *et al.*, [30] and Glickman, N., and Crump, C., [31] reported that individual General Practitioners in their studies acknowledged the risk of misunderstanding and incorrectly assessing and treating deaf clients. In a similar study in the United States, it was discovered that the tendency of deaf people to beE misdiagnosed is high because of communication barriers and the fact that deaf people are likely to have low proficiency in English [18].

Mental health stigma is major issue in Ghana because of misconceptions about its causes. Mental health stigma can negatively affect demand for care and treatment and worsen the condition of patients. It impacts provision of care and health outcomes as stigma prevents people from seeking care, causes family members to avoid their relatives with mental health conditions and makes reintegrating of people with mental health conditions into the community difficult. Even health care workers' attitude towards people with mental health conditions has been found to be negative, with primary health care providers unwilling to care for persons with mental health conditions [32].

Stigma against persons suffering from mental health conditions is therefore an issue that occurs at all levels of care and could have dire consequences on patient care [32]. It is worth noting that although deaf people are not the only people who experience this situation—other persons with disabilities such as blind and physically disabled may encounter similar challenges—deaf people's experiences are likely to be different. The situation is likely to be worse among deaf people due to their unique communication needs and therefore may require a different approach.

The correlation between poverty and difficulty in accessing mental health services is real as manifested in this study. Mental health is a complex issue that requires continues reflection and action. The National Health Insurance Scheme, which is aimed at improving access to health care for poor people, does not cover mental health drugs. There is also limited funding from the Central government. Although some medications which could be used to treat mental health conditions are on NHIS, they do not cover treatment for all mental health conditions. As observed by the National Academies of Sciences, Engineering, and Medicine [32], most centres supplying mental health medicine are often reluctant in stocking these due to the belief that they are less profitable. because they are supposed to be provided for free by government under the Mental Health Act. In the case of Ghana, the National Health Insurance Scheme covers the cost of mental health medicines yet majority of the places in this sector remain unaware or unwilling to prioritise their participation in the provision. This further attests to the low value that is placed on mental health in the country. Additionally, high cost of engaging sign language interpreters when accessing mental health services remains a barrier to deaf people. The absence of any effort to bear such cost particularly by government and or Civil Society Organisations implies deaf people who are poor and experiencing from mental health conditions will remain excluded from needed care owing to the cost involved in using the services of professional interpreters. They have to bear the cost of interpretation services for every review, which will be too expensive for most deaf people who are unemployed.

5. Limitations of the Study

The data collection instruments were written in English and translated into GhSL during the interviews. This requires people who are very fluent in both the GhSL and English language to accurately make the translation during the interview and to transcribe the videotapes into word format. Although efforts were made to minimize errors by using deaf research assistants who were fluent in English, a 100-percentage accuracy cannot be assured.

The application of purposive and convenience sampling techniques in the selection of participants contributed immensely in reaching the respondents. However, these sampling techniques are prone to biases as equal chances may not have been given to participants during recruitment, and selection may have been influenced by researchers' subjective judgement. Also, deaf people who cannot communicate in the GhSL were excluded from this study. This is a big limitation because a large proportion of deaf people do not use GhSL, and the views of these deaf persons were not represented in the study. However, the findings from this study suggest that this category of deaf people may be facing serious challenges accessing mental health care services and the need to target them is crucial. Also, it was time-consuming interviewing deaf participants with mental health conditions because many of them could not articulate their views, while others were not willing to participate in the study or could not be interviewed at a session.

6. Implications of the Study

This study has policy and programmatic implications. Ghana as a Lower Middle-Income Country (LMIC) has challenges providing mental health care for those in need. Some of the challenges are related to invisibility of the needs of some underserved populations, such as deaf people. However, there are no disaggregated data on deaf people in studies on mental health in Ghana. Consequently, very little is known about the challenges that deaf people face when seeking mental health care or how they cope with this complicated system. Understanding the challenges that deaf people in Ghana encounter when using mental health services is therefore the first step to developing accessible and deaf-friendly mental health services. This can also be achieved through evidence-based practices. Finding from this study make the mental health needs of deaf people visible for policy making, service delivery and advocacy. This study is however limited in scope. This means national mental health research should target deaf people and reports disaggregated by type of disability so that the needs of each group would be visible for mental health policymaking and programme designing.

Even though Ghana's National Mental Health Act (846) of 2012 has been hailed for being in harmony with international human rights standards, and best practices in mental healthcare, it does not address the specific concerns of other categories of persons with disabilities. The Mental Health Act of Ghana is too generic, a one-size-fits all law, that does not capture the need of subpopulations, such as deaf people. This implies that policies and guidelines formulated on the basis of the Act, are not likely to address the concerns of deaf people. An instance is the particular challenges relating to the communication barriers deaf persons often encounter when accessing healthcare. The Act therefore needs to be reviewed to incorporate the needs and concerns of the deaf population. Further, mental health policies should avoid lumping all persons with disabilities together and prescribing the same solutions for them because their needs and concerns are not the same.

Findings of the study point to the need to improve on the mental health literacy of deaf people to facilitate early detection and intervention of mental health conditions among them. This can be achieved largely through formal non-residential training programmes for deaf people using a peer education model. There is generally a strong mutual trust among members of the deaf community, where information sharing is strong among members through the "Deaf Grapevine." This is a network of peers and friends passing information from one person to the other [33]. The peer education model based on the "Deaf Grapevine" will therefore facilitate the spread of accurate mental health information among deaf people.

Enhancing communication between deaf people and healthcare workers will not only result in better treatment, but also improved patient compliance and adherence to medication regimes. Communication barriers hindering access to health care in general should be given serious attention in healthcare programmes. However, this is a very complex issue because of the varying communication needs of the deaf community, and the likelihood of breaching the privacy of deaf clients using interpreters. Mental health services providers must work closely with the deaf community to understand their communication needs, and services should be customized to suit the subgroups in the community. Communication options, such as sign language interpreters, lipreading, and writing could be made available for deaf persons seeking health care to choose the options they prefer.

Although there are limitations to the use of social media among deaf people, it has immense potential for media-based dissemination of mental health information for deaf people if the information is presented in formats that are deaf-friendly. Information on mental health issues and its management, could be deployed through social media handles in the GhSL or simple and short sentences to make reading and comprehension easier for deaf people.

This study has implications for social work practice and education in Ghana. Deaf people are a distinct linguistic minority group [34] who encounter communication barriers and hearing loss stigma, but their needs are often not captured in health policies (Author). Those with mental health conditions encounter more challenges as they experience double stigma-stigma associated with hearing loss and having a mental health condition [23]. These increase the vulnerability of deaf people with mental health conditions, making them a "special" group that require greater attention. This therefore points to the need to incorporate disabilities issues in the training of social workers, as required by the Persons with Disability Act 715. Social workers could collaborate with the deaf community to design deaf-specific mental health programmes for the deaf people to increase their utilization of mental health services, prevent isolate, and promote their integration into their communities.

7. Conclusion

It could be seen from the findings that mental health services are not reaching a section of the population despite government efforts. This means that Ghana's quest to reduce the effect of mental health condition on the population is not working well because a portion of the population is not being reached by mental health care services. This situation may adversely affect Ghana's efforts at achieving the Sustainable Development Goal (SDG) 3 which enjoins the global community to ensure healthy lives and promote well-being for all at all ages. The study contributes to knowledge on mental health among an underserved populations and adding to the existing scholarly work on mental health care for marginalized populations. It should be noted that while some of the barriers faced by deaf people may not be different from other groups, such as stigma and negative attitude, different strategies may be required to address the challenges deaf people face.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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