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Telephones and the Provision of Community-Based Mental Health Services in the Northwest and Southwest Regions of Cameroon

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ABSTRACT

The purpose of this study was to investigate the effects of telephones on the provision of community-based mental health services in the Northwest and Southwest Regions of Cameroon. The target population of the study consisted of 405 mental health professionals working in the Northwest and Southwest Regions of the country. The study employed the sequential explanatory mixed methods research design. Quantitative data was collected through a questionnaire while a semi-structured interview guide and an observational checklist were used to collect qualitative data from a sample of 300 mental health professionals. Questionnaires were completed by 275 participants while 15 participants were interviewed and 10 others were observed in the two Regions. The purposive and convenience sampling techniques were used to select the sample. Data were analyzed with the aid of the Statistical Package for Social Sciences (SPSS) version 26.0 for Windows. Descriptive statistics and inferential statistics were used to analyze quantitative data while qualitative data was analyzed using content analysis with the support of ATLAS.ti software version 8.0. The findings revealed that telephones (r=.741, df=273, p=0.001, far < 0.05), have a positive correlation with the provision of community-based mental health services. However, it was observed that inadequate airtime/credit for phone calls and messages, poor electricity supply, mental health professionals' lack of training on telephone use in mental healthcare, and the lack of motivation by mental health practitioners to use telephones for service delivery are limiting factors to telephone use in the provision of community-based mental health services. Based on the findings, recommendations were made to mental healthcare trainers, mental health professionals, vulnerable persons affected by mental disorders, the government and other researchers in Cameroon on measures to enhance telephone use and integration in mental healthcare research and practice.

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KEYWORDS: *Telephones, and Community–Based Mental Health Services*

INTRODUCTION

The telephone is one of the most popular and widely used ICT tools (Farley, 2005). According to Farley (2005), a telephone is a telecommunications device that permits two or more users to conduct a conversation when they are too far apart to be easily heard directly. Car and Sheikh (2003) submit that the telephone is considered an ICT tool because it is a technology used for information and communication. People use telephones to make and receive voice calls and text messages. The telephone is inexpensive, is simple to operate, and offers its users an immediate, personal type of communication that cannot be obtained through any other medium. According to Car and Sheikh (2003), the two main types are fixed phones or landlines and mobile or cellular phones. A landline is a telephone that transmits signals converted from audio data through physical media, such as wire or fibre optic cable, rather than through wireless transmission as is the case with mobile phones. There are two basic types of landlines. A corded landline is one that the phone base and the receiver (or handset) are connected by a cord. In a cordless landline, the phone base is connected wirelessly. Meanwhile, Argyle (2013) states that a mobile or cellular phone refers to a wireless phone which receive its signals from towers and can be

carried around unlike a fixed phone or landline. Both fixed and mobile phones have their analogue or outdated and digital or modern versions. The ICT tool under examination in this study is the telephone.

Watts and Dent (2006) have asserted that there has been growing interest in the use of telephone helplines in mental health services. The telephone in connection with mental health services can be used proactively or reactively (Matkin, Ordóñez-Mena & Hartmann-Boyce, 2019). In a proactive approach, the mental health practitioner initiates one or more calls to provide mental health and psychosocial support (MHPSS) for a client who is making a quit attempt in order to avoid relapse. This can be offered as part of a face-to-face intervention programme. Reactive intervention in contrast is available on-demand to people calling for specific services; quitlines, helplines or hotlines.

Gradually but steadily, mental health practitioners are increasingly incorporating the use of telephones in the provision of their professional services in their communities. According to Young (2008), a good number of these professionals today have telephone gadgets that they utilize in the provision of community-based mental health services. The European Centre for the Development of Vocational Training (2005) insists that one of the challenges that every mental healthcare system currently faces is how practitioners can make the best use of technology such as telephones particularly in providing services for their clients. Akpan (2008) opines that training mental health workers in today's world without including technology would be an absurdity that one cannot imagine.

The improvement of mental health services in community settings of low-and-middle-income countries (LMICs) has been identified as a significant global health priority (Patel, 2014). Toguem, Kumar, Ndetei, Njengoue and Owiti (2022) posit that in Cameroon, mental disorders represent 6.1% of the burden of all diseases. In 2017 for example, mental health disorders accounted for 2366.29 disability-adjusted life years per 100,000 population in Cameroon (WHO, 2018). According to Mviena, Fanne, Gondo, Mwamelo, Esso, Epée and Boum (2020), Cameroon is especially vulnerable to mental health problems due to the challenges of a weak health-care system, an inadequate mental health workforce, insufficient financing to pay for health care, lack of access to mental health prevention and treatment, and the added complexity posed by ongoing humanitarian crises. Additionally, the stigma of mental health problems continues to hinder and discourage individuals from seeking mental health care, further exacerbating the situation (Mviena et al, 2020).

However, the Cameroon Government through the Ministry of Public Health has taken pragmatic steps towards ensuring that mental healthcare is part of its core healthcare systems approach. Following the recommendations of the World Health Organization (WHO, 2015), mental health was introduced in the minimum package of healthcare services in Cameroon in 2016 (Ministry of Public Health a, 2016). According to the first mental health plan and policy in Cameroon that was published in 2016, which is a follow up document of the National Health Development Plan (NHDP) 2016–2020 (Ministry of Public Health b, 2016) emphasis has been placed among others on the following issues: equity and access to mental health services across different groups, quality improvement, and developing effective community mental health services. The present study builds on this to verify whether the use of telephones could improve access, quality and effectiveness of community-based mental health services.

STATEMENT OF THE PROBLEM

Ideally, mental health services of good quality and of high efficacy should be available to all members of a community who are in need of such services. However, from observation and interaction, the provision of community-based mental health services remains poor, insufficient and inadequate, and even absent in some communities in the Northwest and Southwest Regions of Cameroon. This unfortunate situation has been blamed largely on the paucity of mental health professionals to cater for the mental health needs of the population. This is reflected in poor availability of mental health services, difficulty to access existing professionals and services, limited mental health coverage in communities, poor quality of care provided and inadequacies in meeting the mental health goals and objectives set by mental health providers in vulnerable communities. The shortage of mental health practitioners coupled with the growing demand for their services has exacerbated the problem. This growing demand has been linked to the ravaging psychological effects of humanitarian crises affecting the Regions that have exacerbated mental health conditions such as anxiety, depression, post-traumatic stress disorders (PTSD) and phobias among community dwellers. Despite the efforts currently being made by practitioners to improve access, quality and effectiveness of mental health services in these communities, these challenges related to service provision persist. The world has become a global village and with advancements in

technology and changing patterns in the world of work, there is need for mental health practitioners in the Regions to normalize telephone use to enhance service provision. Unfortunately, some mental health professionals lack telephone literacy, others are resistant to change from traditional service delivery methods, and there are limited school-based and in-service training programs that promote telephone education and awareness for integration in mental health. At the moment, community-based mental health services operate at a limited scale amidst concerns that not all practitioners are optimizing telephone use in service provision. Based on the need for comprehensive mental health coverage in the country, there is a distinct possibility that if practitioners maximize the use of telephones, service delivery would be greatly enhanced. This is based on claims from literature that telephones when used in innovative ways can significantly enhance mental health service provision within communities. It was based on this that the researcher sought to investigate the effects of telephones on the provision of community-based mental health services in the Northwest and Southwest Regions of Cameroon.

METHODOLOGY

The sequential explanatory mixed methods research design was used in this study wherein both quantitative and qualitative techniques were used to manage the data collected for the study. The Northwest and Southwest Regions were chosen for this research due to the presence of numerous mental health practitioners such as psychiatrists, psychologists, clinical counsellors, psychiatric nurses, case workers, protection (child, disabilities and gender-based violence) workers and social workers working tirelessly in hospitals, mental health facilities, community based-organizations, international relief organizations, correctional/rehabilitation facilities, private practices and government agencies among others to assuage the mental health problems of vulnerable persons in these two Regions. These communities have a growing number of mental health practitioners, and these mental health practitioners have access to telephones, with some of them making use of this ICT tool as an adjunct to mental health services.

The study targeted 405 mental health professionals in the Northwest (NW) and Southwest (SW) Regions of Cameroon. Meanwhile, the accessible population included 376 mental health professionals working in various institutions and communities across the Northwest and Southwest Regions. The accessible population was based on accessibility given the ongoing Anglophone Crisis in the two Regions. The choice of these two Regions was based on convenience. The sample consisted of 300 participants, 159 participants were selected from the SW while 141 were selected from the NW Region using the purposive and convenience sampling techniques. Accordingly, the population and sample were drawn from the communities of interest in the Northwest Region notably Bali, Bamenda, Fundong, Kumbo East, Kumbo West, Mbengwi, Nkambe, Santa and Tubah and those of the Southwest Region namely Buea, Limbe, Tiko, Mamfe, Kumba North, Kumba South, and Ekona. A questionnaire, a semi-structured interview guide and an observation schedule/guide were used as instruments for data collection.

Table 1: Population and sample distribution table

Regions	Communities	Target Population	Accessible population	Sample
Northwest (19 health communities or districts)	1. Ako	2	2	
	2. Bafut	4	3	
	3. Bali	17	16	12
	4. Bamenda	48	46	44
	5. Batibo	3	3	
	6. Benakuma	5	4	
	7. Fundong	16	15	12
	8. Kumbo East	13	13	10
	9. Kumbo West	9	9	8
	10. Mbengwi	18	17	15
	11. Ndop	1	1	
	12. Ndu	1	1	
	13. Njikwa	1	1	
	14. Nkambe	16	16	13

	15. Oku	**2**	**1**	
	16. Santa	25	23	19
	17. Tubah	21	20	17
	18. Wum North	5	4	
	19. Wum South	2	2	
Southwest (18 health communities or districts)	20. Bangem	2	2	
	21. Buea	37	35	34
	22. Konye	1	0	
	23. Limbe	19	18	16
	24. Eyumedjock	3	2	
	25. Mbonge	4	2	
	26. Mundemba	3	2	
	27. Muyuka	3	3	
	28. Tiko	18	17	15
	29. Bakassi	4	2	
	30. Tombel	2	2	
	31. Akwaya	0	0	
	32. Mamfe	23	20	18
	33. Kumba North	34	33	32
	34. Kumba South	25	25	23
	35. Fontem	2	1	
	36. Ekona	14	13	12
	37. Ekondo Titi	3	2	
Grand total		405	376	300

Source: OCHA Cameroon, 2022; WHO Health Cluster, 2020; MINSANTE NW & SW; MHPSS TWG NW_SW; and UNFPA Database for Implementing Mental Health Organizations (Researcher's Survey, 2022).

Validation of the instruments was done by the researcher, his classmates, the supervisors, some practising mental health professionals and the statistician so as to ensure validity through face validity, content validity and construct validity. A pilot study was carried out on 10 mental health professionals working in Bamenda, who were not part of the sample to ensure reliability of the instruments. Reliability of the instruments was computed and obtained using the Cronbach Alpha coefficient of internal consistency using the Statistical Package for Social Sciences (SPSS) software version 26.0. After the instruments were constructed and their validity and reliability was ascertained, the researcher proceeded to collect data immediately using both personally (self-delivery) and through colleagues (research assistants) using the snowball technique.

Data was analyzed quantitatively using the Statistical Package for Social Sciences (SPSS) software version 26.0. Descriptive statistics such as frequencies tables containing the various weighted responses, percentages, measures of central tendencies (mean), and dispersion (standard deviation) were generally used to provide answers to the research questions. The Pearson product moment correlation test was also used to compare means within the variables under investigation, thereby supplying the inferential statistics for this study. The Pearson product moment correlation was used to determine the magnitude and direction of the relationship between telephones and the provision of community-based mental health services. Qualitative data obtained from the interviews and observations were analyzed using the technique of content analysis and the ATLAS.ti software version 8.0 (Friese, 2011). Ethical issues such as informed consent, voluntary participation, confidentiality, access to the community, and creation of friendly rapport were taken into consideration during data collection and analysis.

RESULTS

Demographic Profile of the Respondents

Demographic profile of the research sample is presented in this section in the form of tables and charts.

Table 2: Distribution of respondents according to Mental Health Professions

Mental health professions	Frequency	Percentages
Clinical counsellors	108	36%
Psychologists	24	8%
Psychiatrists	18	6%
Psychiatric nurses	39	13%
Social workers	30	10%
Protection workers	45	15%
Case workers	36	12%
Total	**300**	**100%**

Table 2 above represents the distribution of respondents according to the Mental Health Professions. Out of the 300 respondents selected for this study, 108 (36%) of them were clinical counsellors, 24 (8%) of them were psychologists, 18 65%) of them were psychiatrists, 39 (13%) were psychiatric nurses, 30 (10%) were social workers, 45 (15%) were protection workers while 36 (12%) of them were case managers indicating that clinical counsellors dominated the study.

Figure 1: Distribution of respondents according to Gender

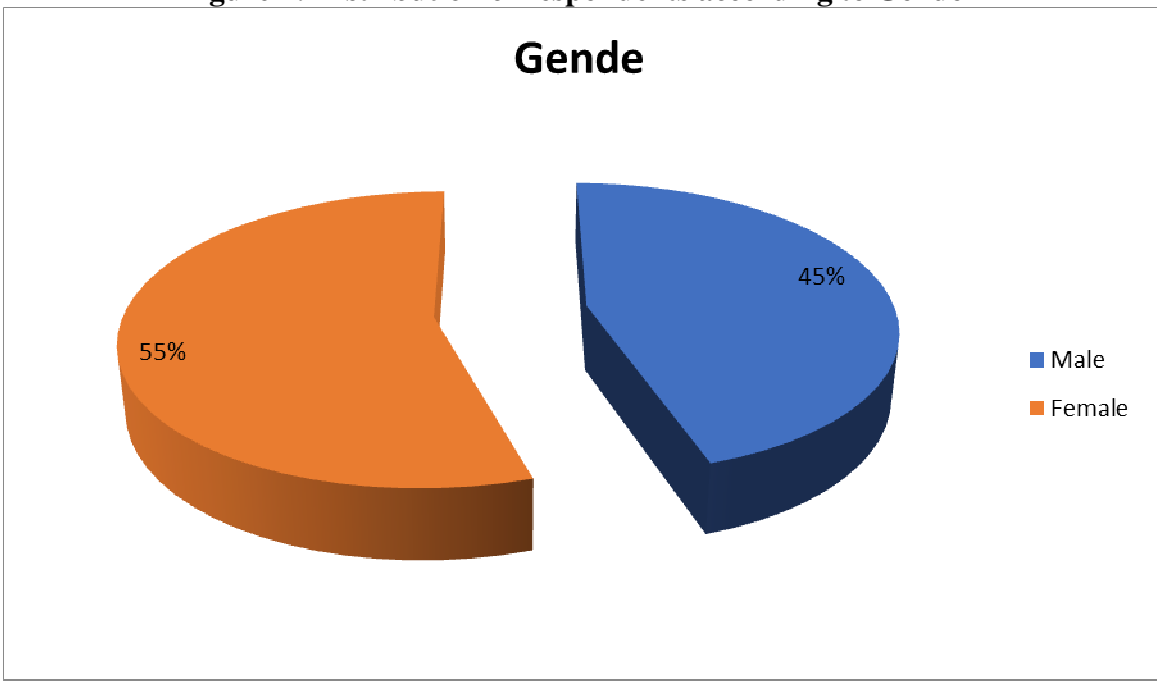

Figure 1 above displays the distribution of the respondents according to Gender. Out of the 300 respondents selected for this study, 165 (55%) of them were females and 135 (45%) of them were males indicating that the females dominated the study.

Table 3: Distribution of respondents according to Age

Age range	Frequency	Percentages
Below 35 years	129	43%
35-44 years	114	38%
45-60 years	57	19%
Total	**300**	**100%**

Table 3 above showcases the distribution of respondents according to the Age. Out of the 300 respondents selected for this study, 129 (43%) of them were below 35 years, 114 (38%) of them were within the 35-44 years age bracket, while 57 (19%) of them were aged 45-60 years.

Figure 2: Distribution of respondents according to Region

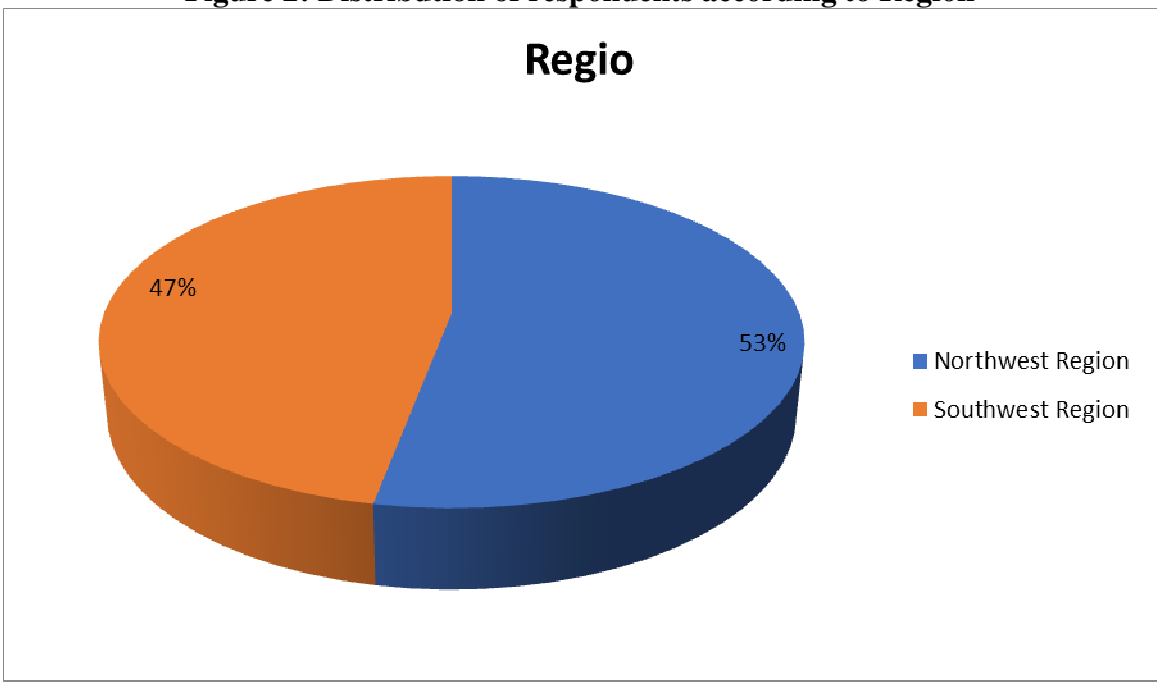

Figure 2 above shows the distribution of the respondents according to Region. Out of the 300 respondents selected for this study, 159 (53%) of them were from the Northwest Region while 141 (47%) of them were from the Southwest Region.

Table 4: Distribution of respondents according to Experience

Experience	Frequency	Percentages
0-10 years	186	62%
11-20 years	93	31%
21 years and above	21	7%
Total	**300**	**100%**

Table 4 above showcases the distribution of respondents according to the Experience. Out of the 300 respondents selected for this study, 186 (62%) of them had 0-10 years of job experience, 93 (31%) of them were within 11-20 years job experience while 21 (7%) of them had job experience of 21 years and above.

Figure 3: Distribution of respondents according to Location

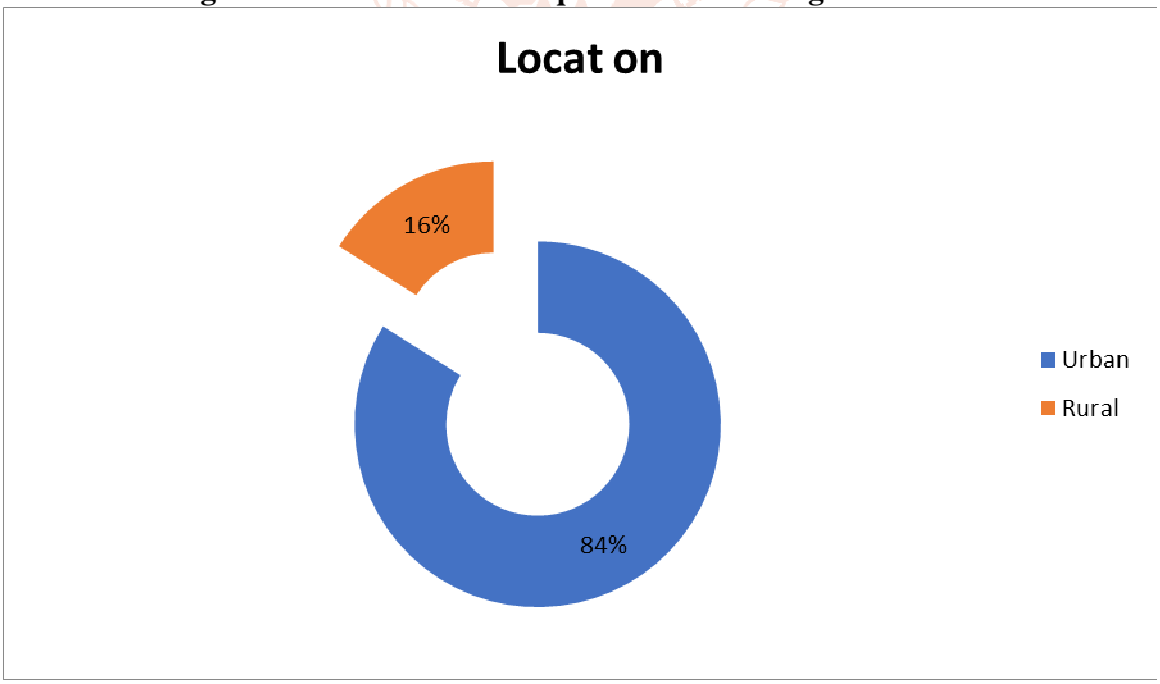

Figure 3 above illustrates the distribution of the respondents according to Location. Out of the 300 respondents selected for this study, 252 (84%) of them were from urban locations while 48 (16%) of them were from rural locations.

Table 5: Distribution of respondents according to Academic Qualifications

Academic qualifications	Frequency	Percentages
Bachelor's Degree	105	35%
Postgraduate Diploma	60	20%
Master's Degree	126	42%
PhD	9	3%
Other	0	0%
Total	**300**	**100%**

Table 5 above portrays the distribution of respondents according to the Academic Qualification. Out of the 300 respondents selected for this study, 105 (35%) of them had a Bachelor's Degree, 60 (20%) of them had Postgraduate Diploma, 126 (42%) had earned Master's Degrees, only 9 (3%) of them had a terminal degree (PhD) while none (0%) had other academic qualifications.

Figure 4: Distribution of respondents according to Training in ICTs

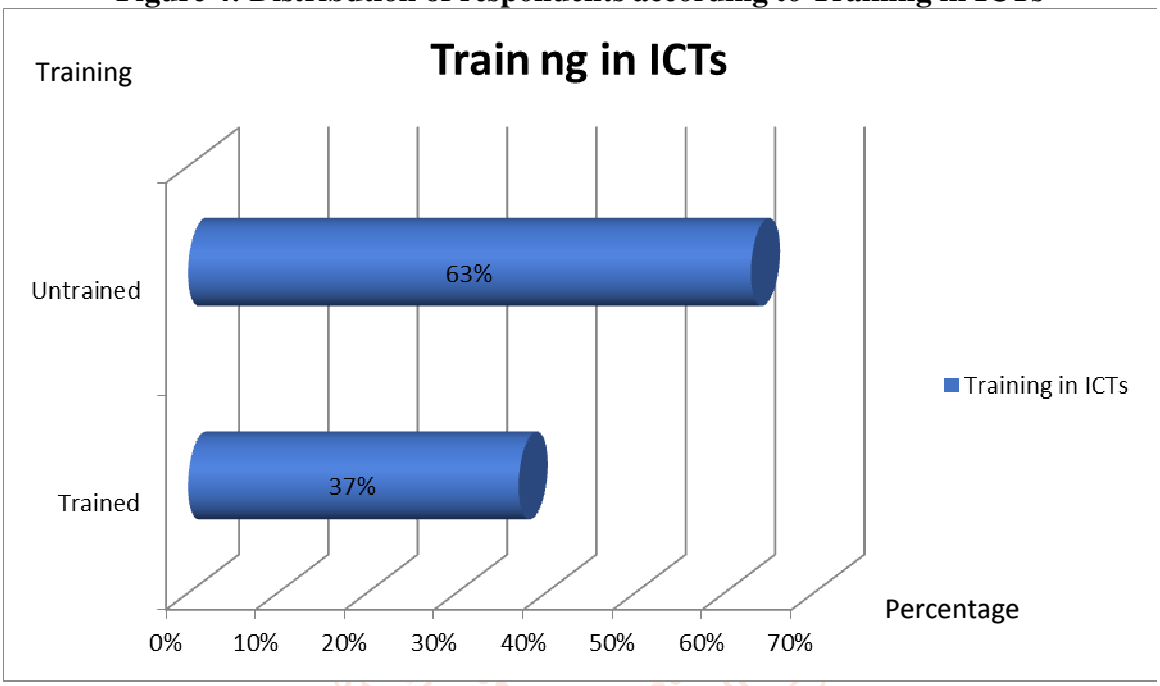

Figure 4 above describes the distribution of the respondents according to training in ICTs. Out of the 300 respondents selected for this study, 189 (63%) of them were trained in ICTs while 111 (37%) of them had not received any training in ICTs.

Figure 5: Distribution of respondents according to Working Language

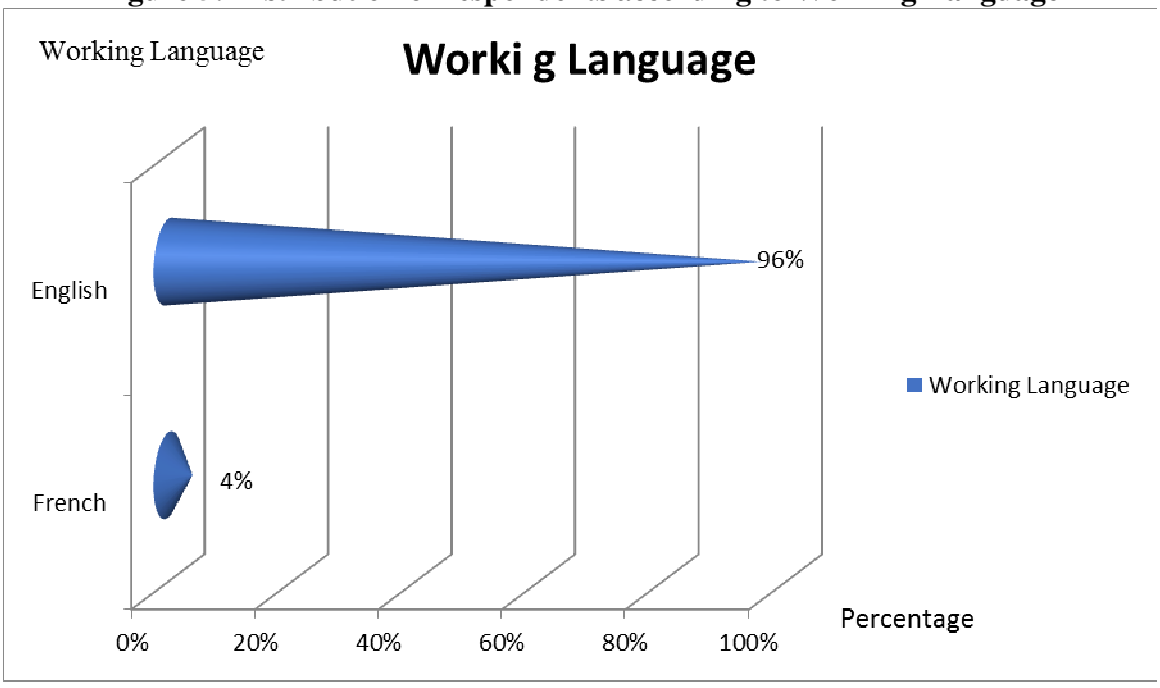

Figure 5 above illustrates the distribution of the respondents according to Working Language. Out of the 300 respondents selected for this study, 288 (96%) of them had English as their working language while for 12 (4%) of them French was their working language.

Table 6: Distribution of respondents according to Work Setting

Work setting	Frequency	Percentages
Hospitals	69	23%
NGOs and community Organizations	105	35%
Mental health clinics	18	6%
Government agencies	51	17%
Correctional/rehab facilities	33	11%
Private practices	24	8%
Total	**300**	**100%**

Table 7 above shows the distribution of respondents according to Work Setting. Out of the 300 respondents selected for this study, 69 (23%) of them were from hospitals, 105 (35%) were from NGOs/Community organizations, 18 (6%) of them were from Mental health clinics, 51 (17%) of them were from government agencies, 33 (11%) of them were from correctional/rehabilitation facilities, while 24 (8%) of them were from private practices.

Research question one: What is the extent to which telephones affect the provision of community-based mental health services in the Northwest and Southwest Regions of Cameroon?

Table 7: Questionnaire responses on telephones and the provision of community-based mental health services

	Stretched				Collapsed					
ITEMS	SA	A	D	SD	SA+A	D+SD	N	MEAN	S. DEV	RANK
I use the telephone to provide initial disaster response intervention to promote safety, stabilize survivors and connect individuals to help and resources.	121 (44%)	129 (47%)	19 (7%)	6 (2%)	250 (91%)	25 (9%)	275	1.67	0.69	2
I use the telephone to provide individual and group counselling for clients with mental disorders.	39 (14%)	52 (19%)	96 (35%)	88 (32%)	91 (33%)	184 (67.0%)	275	2.85	1.02	10
I use the telephone to coordinate community services and connect clients with the resources they need.	126 (46%)	113 (41%)	22 (8%)	14 (5%)	239 (87%)	36 (13%)	275	1.71	0.81	3
I use the telephone to associate clients with services that protect children, survivors of gender-based violence and persons with disabilities against abuse and neglect.	85 (31%)	148 (54%)	14 (5%)	28 (10%)	233 (85%)	42 (15%)	275	1.93	0.86	8
I use the telephone to provide training sessions to members of the community about mental health wellness promotion, prevention and treatment.	85 (31%)	146 (53%)	27 (10%)	17 (6%)	231 (84%)	44 (16%)	275	1.92	0.81	7
I use the telephone to collect information and build case history in order to make appropriate mental health diagnoses.	129 (47%)	132 (48%)	11 (4%)	3 (1%)	261 (95%)	14 (5%)	275	1.58	0.61	1
I use the telephone to follow up with clients on their treatment plans in line with set goals for therapy.	118 (43%)	126 (46%)	17 (6%)	14 (5%)	244 (89%)	31 (11%)	275	1.72	0.77	4

I use the telephone to provide additional support and follow-up in areas such as support groups, vocational rehabilitation and outdoor activities that generally promote the health and wellbeing of clients.	102 (37%)	113 (41%)	30 (11%)	30 (11%)	215 (78%)	60 (22%)	275	1.94	0.95	9
I use the telephone to plan meetings, book appointments, and work with colleagues and hierarchy to enhance mental healthcare for clients.	113 (41%)	129 (47%)	22 (8%)	11 (4%)	242 (88%)	33 (12%)	275	1.74	0.76	5
I use the telephone to source for accurate, relevant information from supervisors, colleagues and the community.	85 (31%)	151 (55%)	22 (8%)	17 (6%)	236 (86%)	39 (14%)	275	1.88	0.78	6
I use the telephone to refer clients to specialists for the help they need.	96 (35%)	121 (44%)	27 (10%)	31 (11%)	217 (79%)	58 (21%)	275	1.94	0.93	9
Multiple Response Set (MRS)	**36%**	**45%**	**10.0%**	**9%**	**81%**	**19%**	**275**	**1.90**	**0.99**	

SA-Strongly Agree; A-Agree; D-Disagree; SD-Strongly Disagree;
Source: Researcher's field survey, 2022.

Table 7 shows the distribution of questionnaire responses according to the use of the telephone and the provision of community-based mental health services. Mental health professionals' opinions were sought on eleven items to examine the extent to which the use of the telephone affects the provision of community-based mental health services. Based on the collapsed responses, that is agreed (SA + A) and disagreed (D + SD), their responses were depicted as follows: Out of the 275 mental health professionals, 250 of them agreed (91%) as opposed to 25 who disagreed (9%) that they use the telephone to provide initial disaster response intervention to promote safety, stabilize survivors and connect individuals to help and resources for clients. Out of the 275 mental health professionals, 91 (33%) of them agreed as opposed to 184 (67%) who disagreed that they use the telephone to provide individual and group counselling for clients with mental disorders. Also, out of the 275 mental health professionals, 239 (87%) of them agreed as opposed to 36 (13%) who disagreed that they use the telephone to coordinate community services and connect clients with the resources they need.

In addition, out of the 275 mental health professionals, 233 (85%) of them agreed as opposed to 42 (15%) who disagreed that they use telephone to associate clients with services that protect children, survivors of gender-based violence and persons with disabilities against abuse and neglect. Furthermore, out of the 275 mental health professionals, 231 (84%) of them agreed as opposed to 44 (16%) who disagreed that they use telephone to provide training sessions to members of the community about mental health wellness promotion, prevention and treatment. Again, out of the 275 mental health professionals, 261 (95%) of them agreed as opposed to 14 (5%) who disagreed that they use telephone to collect information and build case history in order to make appropriate mental health diagnoses. Besides, out of the 275 mental health professionals, 244 (89%) of them agreed as opposed to 31 (11%) who disagreed that they use the telephone follow up with clients on their treatment plans in line with set goals for therapy.

Furthermore, out of the 275 mental health professionals, 215 (78%) of them agreed as opposed to 60 (22%) who disagreed that they use telephone to provide additional support and follow-up in areas such as support groups, vocational rehabilitation and outdoor activities that generally promote the health and wellbeing of clients. Moreover, out of the 275 mental health professionals, 242 (88%) of them agreed as opposed to 33 (12%) who disagreed that they use telephone to plan meetings, book appointments, and work with colleagues and hierarchy to enhance mental healthcare for clients. Also, out of the 275 mental health professionals, 236 (86%) of them agreed as opposed to 39 (14%) who disagreed that they use the telephone to source for accurate, relevant information from supervisors, colleagues and the community. Finally, out of the 275 mental health professionals, 217 (79%) of them agreed as opposed to 58 (21%) who disagreed that they use the telephone to refer clients to specialists for the help they need.

Cumulatively, based on the findings, the majority (81%) of the respondents agreed that telephones affected the provision of community-based mental health services as opposed to those (19%) that disagreed. This therefore revealed that the use of the telephone enhances the provision of community-based mental health services in the Northwest and Southwest Regions of Cameroon to a high extent.

Analysis of the Interview Guide

This section addresses the interview responses based on the views gathered from the fifteen (15) mental health program managers used in the study. Their views on telephones with respect to the provision of community-based mental health services are presented in line with their responses to the interview questions analyzed following qualitative content analysis method with the aid of ATLAS.ti software version 8.0. It makes use of the Qual-quan dominant paradigm and presents an exploratory thematic view of the interviewed cases by essentially highlighting dominant quotations that correspond to emerging themes based on the coded and analyzed transcripts and field notes.

Mental health program managers were asked about their views concerning the use of the telephone in the mental healthcare profession. Based on their responses, the emerging themes and dominant quotations that emerged are presented in the following table. Cases 10, 13 and 8 respectively expressed dominant positive views on the subject and were selected for thematic illustration based on their explanatory excerpts.

Table 8: Views concerning the use of the telephone in the mental healthcare profession

Emerging Themes	Dominant Quotations
Improves service provision	Case 10: *"When mental health professionals make use of the telephone as an ICT tool, it enables them to become more competitive and professional in the present globalised and industrialised society and it improves service provision and delivery especially when blended with face-to-face mental health interventions. I must say using the telephone has greatly improved service provision for me."*
Opportunity for greater outreach to clients	Case 13: *"Using the telephone in the provision of community-based mental health services enables the mental health professional to reach out to more clients and patients especially those that are too shy to meet face-to-face and those that are too busy to devote time for in-person sessions due to their tight schedules. Hence, using the telephone provides an opportunity for greater outreach to more clients or patients"*
Acts as a helpline	Case 8: *"The telephone acts as a helpline to clients or patients in distant places or who are not readily available but are in dire need of professional mental health services in the community as well as for those who at the brink of relapse and may just be a call or text away from having a major mental breakdown. Do you know I have saved the lives of many persons who were about to commit suicide due to depression when I called them and spoke to them on phone? Today, it gives me joy to say that they are fine."*

Source: Researcher's field interviews, 2022

Based on the respondents' views on the use of the telephone in the mental health profession, 14 out of 15 of the mental health program managers were of the opinion that the use of the telephone helps to improve the provision of community-based mental health services. Majority of the respondents, 13 out of the 15 of them, were of the opinion that the telephone provides an opportunity for greater outreach to clients especially those in distant places, volatile locations and enclaved zones or rural areas. Meanwhile, most of the respondents, 14 out of the 15 of them, held the view that the telephone, when implicated in mental health service provision acts as a helpline for clients especially those who are trying struggling to quit bad habits such as smoking and embrace new dispositions. This is because the calls and text messages act as a regular and constant reminder to refocus on therapeutic goals and treatment plans.

Mental health professionals were also asked about their experience with the use of the telephone in the provision of community-based mental health services. Based on their responses, the emerging themes and dominant quotations that emerged are presented in the following table. Cases 4, 9 and 6 respectively expressed dominant interesting views on the subject and were selected for thematic illustration based on their explanatory excerpts.

Table 9: Views concerning mental health professionals' experience with the use of the telephone in the provision of community-based mental health services

Emerging Themes	Dominant Quotations
Acts as a very useful tool for work related activities	Case 4: *"Based on my field experiences with the telephone, I must say this ICT tool helps to facilitate my tasks as a mental health professional such as providing counselling to clients, obtaining vital information from clients and organising meetings and other administrative and research duties. Therefore, the telephone acts as a very useful tool for work-related activities in mental healthcare."*

Works as a quick fix when distance is a barrier	Case 9: *"Sometimes, while working on the field, we meet vulnerable community-members in need of mental health services, but due to time constraints, we are not be able to complete service delivery. The telephone acts as a quick fix to complete the process even over a distance. When I need new or supplementary information from clients, I just call or text them and they supply it to me directly so that I can better assist them in the rehabilitation process."*
Usage becomes second-nature over time	Case 6: *"Our society started by using fixed phones, then we moved to mobile phones and today we are increasingly using smartphones that perform more sophisticated operations. I have been working as a mental health professional for close to 10 years and must say that over time, my skills of using the telephone have increased. When I started, I faced great difficulty manipulating the phone and sending texts and making work-related calls but now it is second nature to me."*

Source: Researcher's field interviews, 2022

Based on the respondents' views on their experiences with the use of the telephone in the provision of community-based mental health services, majority of them, 13 out of 15 of them, were of the opinion that the telephone acts as a very useful tool for mental health and other related activities given that calls and text messages facilitate mental proceedings, activities and operations. Eleven (11) out of the 15 mental health program managers were of the opinion that the telephone works as a quick fix when distance is a barrier in that the gadget bridges the gap between practitioners and clients when they are geographically far apart. Meanwhile, most of the respondents, 14 out of the 15 of them, held the view that the usage of the telephone becomes second nature over time given that with more frequent and regular use, the practitioner advances on his knowledge and use of the device for mental health purposes.

Mental health program managers were also asked whether their use of the telephone improved the overall access, quality and effectiveness of community-based mental health services provided by their institutions. Based on their responses, the emerging themes and dominant quotations that emerged are presented in the following table. Cases 2, 5 and 15 respectively expressed dominant interesting views on the subject and were selected for thematic illustration based on their explanatory excerpts.

Table 10: Views on how telephone use has improved overall access, quality and effectiveness of community-based mental health services provided

Emerging Themes	Dominant Quotations
Enhances access	Case 2: *"Using the telephone enhances access to community-based mental health services. By using the telephone, I have been able to reach out to many more clients than ever before and the number of clients that have had access to the mental health services my institution provides has increased tenfold and continues to grow rapidly. This is because distance is no longer a barrier to access mental healthcare."*
Improves quality	Case 5: *"Ever since I started using telephony in mental health activities, the quality of work done has improved tremendously from 23% to 92% and my employers are so elated about it. This helps to improve the quality of work done especially in a fast-paced work environment where one can speak with a patient directly on phone and get accurate information. Every mental health professional should embrace telephone use to improve on the quality of their work."*
Encourages effectiveness	Case 15: *"The telephone encourages effectiveness by the conduct and delivery of work within timelines and deadlines especially when the pressure is on. Sometimes, just a phone call or text message gets you the results you need and saves time. I really enjoy using the telephone to increase my effectiveness as a professional mental health worker because almost everyone has a phone and I can easily reach them to achieve my projected results on time."*

Source: Researcher's field interviews, 2022

Based on the respondents' views on how telephone use has improved overall access, quality and effectiveness of community-based mental health services provided, majority of them, 12 out of 15 of them, were of the opinion that the use of the telephone improves access to mental healthcare given that distance is no longer a barrier to access community-based mental health services. Twelve (12) out of the 15 mental health program managers were of the opinion that telephone usage improves quality especially in situations where a mental health

professional could speak to a client on phone and get accurate additional information. Meanwhile, most of the respondents, 13 out of the 15 of them, held the view that the usage of the telephone encourages effectiveness given that a phone call or text message can get the mental health professional the results he/she needs within timelines and deadlines.

The explanatory excerpts of the interviewed cases present the telephone as an indispensable ICT tool which enhances the provision of community-based mental health services. Against this backdrop, the telephone is seen as an effective tool for the provision of community-based mental health services as supported by the cases who asserted that it improves overall access, quality and effectiveness of community-based mental health services offered by their organizations.

Analysis of the Observational Checklist

This section addresses the responses to the observational checklist based on the data gathered from the observation of 10 functional mental health practitioners at their place of work. Based on the observations made on the field, the findings on telephones with respect to the provision of community-based mental health services are presented in Table 11 below:

Table 11: Observation responses on telephones and the provision of community-based mental health services

Criteria	Exceeds expectations in all respects	Meets expectations in all respects	Meets expectations in most respects	Meets expectations in some respects	Meets expectations in few or no respects	Collapsed		
						Yes	No	N
There is a fixed or mobile phone available at the office for work-related use.			3		7	3	7	10
The telephone device is owned or provided by the organization.			2		8	2	8	10
The phone is in good working order.			3	5	2	3	7	10
The phone has airtime.			4	4	2	4	6	10
The phone is used for mental health services or related activities.	8	1		1		9	1	10
The use of the telephone improves mental health and related activities in terms of access, quality and effectiveness.	8	1	1			10	0	10

Yes= Exceeds expectations in all respects, meets expectations in all respects and meets expectations in most respects; No= Meets expectations in some respects and meets expectations in few or no respects

Source: Researcher's field observation, 2022

Table 11 shows the distribution of the responses on telephones and the provision of community-based mental health services based on the 10 mental health offices observed. The results revealed that there was inadequacy in telephone availability as majority of the observed cases, 9 out of 10, did not possess phones for work-related use. Most of the cases, 8 out of 10, used their personal phones for work-related purposes since the organisations they were working for did not provide them with a telephone gadget for work-related use. Majority of the cases, 7 out of 10, did not possess a phone in good working order. More than half of the cases, 6 out of 10, lacked adequate airtime for calls and messages. However, it was noted that almost all the cases, 9 out of 10, used their phones for mental health services or related activities. The observation revealed that all (10) of the cases believe the use of the telephone improves mental health and related activities in terms of access, quality and effectiveness.

Verification of Hypothesis

Ho: There is no significant relationship between telephones and the provision of community-based mental health services in the Northwest and Southwest Regions of Cameroon.

The hypothesis sought to verify whether there is a significant relationship between telephones and the provision of community-based mental health services in the Northwest and Southwest Regions of Cameroon. The results are presented in table 24 below:

Table 24: Correlation between telephones and the provision of community-based mental health services

Variable		Telephones	The provision of community-based mental health services
Telephones	Pearson Correlation	1	.741**
	p-value		.001
	N	275	275
The provision of community-based mental health services	Pearson Correlation	.741**	1
	p-value	.001	
	N	275	275
NB: Correlation is significant at the 0.05 level (2-tailed).			

There is a significant relationship between telephones and the provision of community-based mental health services (r=.741, df=273, p=0.001, far <0.05). Based on the fact that the significance level of the hypothesis is above 0, the null hypothesis was rejected while the alternative hypothesis was retained. This provided supportive inferential evidence to conclude that there is a significant positive relationship between telephones and the provision of community-based mental health services in the Northwest and Southwest Regions of Cameroon. This means that a unit increase in the use of telephones leads to a corresponding unit increase in the provision of community-based mental health services.

Hence, based on the results of Pearson correlation test conducted (r=.741, df=273, p<0.001, far <0.05), the conclusion is that there is a significant positive relationship between telephones and the provision of community-based mental health services in the Northwest and Southwest Regions of Cameroon.

DISCUSSION

Telephones and the Provision of Community-Based Mental Health Services

The study aimed at examining whether there is a significant correlation between telephones and the provision of community-based mental health services in the Northwest and Southwest Regions of Cameroon. The finding implies that there is a positive correlation between telephones and the provision of community-based mental health services. This indicates that the use of telephones significantly enhances the provision of community-based mental health services.

This finding is in line with the Technology Acceptance Model (TAM) where Davis (1989) theorizes that when users (mental health practitioners in this case) are presented with a new technology, a number of factors influence their decision about how and when they will use it. TAM states that user acceptance of new technology is affected by perceived usefulness and perceived ease of use, whereby perceived usefulness is the degree to which a user believes that using a particular technology would improve his job performance while perceived ease of use is the degree to which a person believes using a particular technology will be free of effort (Davis, 1989). Accordingly, mental health professionals in the Northwest and Southwest Regions of Cameroon are increasingly accepting to use ICTs especially the telephone to conduct mental health services in communities based primarily on their individual perceptions on the usefulness and ease of use of these ICT tools in promoting extensive provision of community-based mental health services. In this regard, more of them are increasingly making use of the telephone in service delivery because of its added value to work activities.

This finding is in agreement with MINESEC (2022) whereby Cameroon's Minister of Secondary Education Prof. Naloval Lyonga on the occasion of the 20th edition of the National Guidance and Counselling Day (NGCD) celebrated on Friday the 21st of October 2022 called for the digitalization of guidance counselling and mental health services in Cameroon schools. In line with this novelty, the minister enjoined members of the school community in Cameroon to make use of the telephone helpline as from the 2022/2023 school year to consult their guidance counsellors online using the hotline 242 237 000 which has now been changed to 1530. The line which is already operational receives calls to provide psycho pedagogic assistance to learners at all levels of secondary school from 7am to 6pm daily. This hotline is a move by the Cameroon Government to ease access to counselling and mental health services.

The finding is also in consonance with Watts and Dent (2006) who indicated that the use of the telephone in mental health has been so effective that the telephone has become normalized as a medium for the provision of community-based mental health services in ways that have yet to happen in the case of computer-mediated communications. Based on their study, the telephone in connection with mental health services can be proactive or reactive. In a proactive approach, the mental health practitioner initiates one or more calls to provide mental health and psychosocial support (MHPSS) services for a client

who for example is making a quit attempt in order to avoid relapse. This can be offered as part of a face-to-face intervention programme. Reactive intervention in contrast is available on-demand to people calling for specific services, for example quitlines, helplines or hotlines.

The finding is also in agreement with Elder, Wildey, De Moor, Sallis, Eckhardt, Edwards, Erickson, Golbeck, Hovell and Johnston (2011) who stated that direct one-to-one telephone interventions appear to provide cost-effective community-based mental health services especially when it comes to behaviour modification especially in clients who suffer from drug or some form of addiction. It is essential to note that the telephone is typically more readily available, convenient, and less burdensome (with respect to travel and time constraints) than face-to-face contact for clients. This finding is also in line with Castro and King (2002) who stated that the telephone enables people to communicate with others all over the world. Against this backdrop, a lot of people use the telephone for different communication purposes but when used by mental health practitioners in a professional manner it enhances community-based mental health services and boosts access, quality and effectiveness of these services.

CONCLUSIONS

Telephones have proven to be necessary in the provision of community-based mental health services in the Northwest and Southwest Regions of Cameroon especially in the post-Covid era. It was recommended that mental health professionals should increase their mastery of the use of telephones in mental healthcare. This can be achieved by enrolling in short courses or training programs as well as organizing, attending and participating in capacity building workings and training seminars. Training colleges and universities should incorporate and strengthen telephone integration training in their mental health programs. They should also ensure that such training is based on equipping the mental health trainees with skills on actual integration of telephones in mental health practice in clinical, school, hospital and other community settings. Further research should be carried out to investigate the use of telephones and its effects on the provision of community-based mental health services in the French Speaking Regions of Cameroon to compare the findings against this one.

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