SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA

CHALLENGES OF REINTEGRATING ADOLESCENTS WITH MENTAL DISORDERS INTO THE MADINA COMMUNITY

BY
MOHAMMED ZABADO, SAHL
10260427

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JULY, 2017
DECLARATION

I, Sahl Mohammed Zabado hereby declare that, this research work is the result of my own original research; all references made to other related literature prepared by other people have been duly cited and acknowledged. This piece has not been presented for an award of a certificate in this university or elsewhere.

................................................................. .................................................................
Sahl Mohammed Zabado Date
(Student)

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Dr. Abdallah Ibrahim Date
(Supervisor)
DEDICATION

This academic work is dedicated to the Almighty Allah for the knowledge and strength bestowed on me during this programme.

To my dear parents Mr. Abdul Razak Mohammed Zabado, Manye Maku and my sister Thahiyat Mohammed Zabado I am eternally grateful for your love and support.

Also to the following very influential people in my life: Mr. Francis Adzinku, Dr. Frank Baning, Selina Yeboah Okyere –Addo and Rabiu Maude for their unflinching love and support.

Allah bless you all.
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This dissertation is what it has become as a result of the efforts of some distinguished individuals.

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Thank you Jasmin Godding, Shamya Smith, Valerie Belize all of Florida Agricultural and Mechanical University (FAMU) in Florida, USA for helping with data collection.

To the entire staff and management of Pantang Hospital thank you for your immense contribution to this study.
ABSTRACT

Background: Worldwide, about 450 million people suffer from mental illness. About 10-20% of the total number of persons with mental illness are adolescents. It is estimated that about 2.5 million of the 27 million Ghanaians have mental illness. It is widely expected that after treatment at the psychiatric hospitals they should be able to integrate fully into the community. However, reports from the Pantang hospital records department suggest that 5% of adolescents discharged from the hospital are not easily reintegrated as anticipated. The theoretical framework of this study is the public health perspective, which involves looking at reintegration as a means of reducing risk factors and strengthening those, which tend to improve or maintain health. The objective of the study was to determine the challenges faced by the patients and their families towards their reintegration. The study also looked at the health system challenges of reintegration and the factors in the community that militate against the successful reintegration of such patients.

Method: The study method and design was qualitative and case study respectively whilst purposive sampling was used to recruit fifty (50) participants from the Madina Municipality. Interviews and focus group discussions were used to gather data about experiences of adolescents with mental disorders, their relatives, the members of the community in which these adolescents live, and the health professionals who render quality mental health service to them.

Findings: The study found community assisted psychiatric nursing services to be very valuable for adolescents in the midst of excessive stigma but also very inadequate to meet the growing demands. The findings also suggested that adolescent’s reintegration is done hurriedly without recourse to proper planning. Furthermore knowledge of family and
community members on the need for changing negative perceptions of the mentally ill is lacking. Cost of mental healthcare in the facilities is a burden on the public purse’. Social isolation and low self-esteem have been found to be contributory factors that militate against reintegration. With regards to the health system challenges, lack of capital investments in infrastructure, lack of medicines and the non-existence of community based support systems (halfway homes and independent living homes) etc. have been cited as major constraints to the mental health sector and the reintegration drive.

**Conclusion**: The study provides indepth insight into the challenges faced by adolescents and their caregivers towards their reintegration. It highlighted the need for a collective and collaborative approach amongst the various stakeholders in achieving the goal of deinstitutionalization of mental healthcare.
# DEFINITION OF KEY TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Adolescent</td>
<td>A young person usually between the ages of 13 to 25 years of age</td>
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<tr>
<td>Caregivers</td>
<td>Relatives providing care to the adolescent with mental disorders</td>
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<tr>
<td>Discrimination</td>
<td>The unjust treatment of the adolescent with mental disorders</td>
</tr>
<tr>
<td>Mental disorder</td>
<td>Disorder that affects the mood, behavior and thinking</td>
</tr>
<tr>
<td>Reintegration</td>
<td>Restoring the mentally disordered back into the community</td>
</tr>
<tr>
<td>Stigma</td>
<td>Mark of disgrace on the adolescent with mental disorders</td>
</tr>
<tr>
<td>Half way homes</td>
<td>It’s a place for people recovering from mental illness and drug related disorders to learn skills for reintegration</td>
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<th>Description</th>
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<tr>
<td>DALY</td>
<td>Disability Adjusted Life Years</td>
</tr>
<tr>
<td>GHS</td>
<td>Ghana Health Service</td>
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<tr>
<td>MHA</td>
<td>Mental Health Authority</td>
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<td>WHO</td>
<td>World Health Organization</td>
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CHAPTER ONE
INTRODUCTION

1.1 Background to the study

Mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain disability or an important loss of freedom (DSM V). Some of these mental disorders include depression, anxiety, Schizophrenia, affective disorder and substance misuse. Mental health is not merely the absence of illness and is defined by the World Health Organization as a state of wellbeing in which the individual realizes his or her own abilities, is able to with cope with normal stresses of life, work productively and fruitfully and is able to make a contribution to his or her community (WHO, 2005). Mental illness is indiscriminate and can be experienced by people from all cultures and socio-economic backgrounds (Patel, 2001).

Worldwide, about 450 million people suffer from mental illness. About 10-20% of the total number of persons with mental illness are adolescents.

The mentally ill is generally faced with two major challenges; one of which is being mentally sick and the other is being discriminated and stigmatized against (Corrigan & Watson 2002). These two translates into a huge burden for them. It is estimated that out of the 27 million Ghanaians about 2.5 million are suffering from severe mental disorders and a further 2,166,000 are suffering from a moderate to mild mental disorder (Osei, Roberts, & Crabb, 2011). It is widely expected that people suffering from mental illness in Ghana should recover and get back into the society to assume their roles and functions properly.
But this is not the case in Ghana, due to a myriad of challenges they face within and without the institutions of care.

In a study aimed at exploring stigmatization and discrimination experienced by persons with mental illness in the Pantang Community a suburb of the study area, the findings revealed that in their daily lives, persons with mental illness who were medication compliant and functioning well in society experienced stigma and discrimination from various groups of people (Darko-Gyeke & Asumang, 2013).

Mental health care has certain social and attitudinal challenges associated with it worldwide. Some of the prominent challenges of mental healthcare worldwide include stigma, discrimination and fear of being attacked by persons with mental illness. These attitudinal factors have hindered the recovery and reintegration of some patients who have been declared fit to go back into their communities. Owing to resource constraints and the stigma attached to mental illness, majority of the population suffering with psychiatric conditions are not treated with modern medicine; instead, they are sent to spiritual churches or prayer camps where they are sometimes severely mistreated (ACCA, 2013). In some instances, individuals with mental health issues may be held in police custody for long periods without treatment. In cases where mental health patients who are able to get inpatient treatment at facilities are discharged from care, they face stigma from their illness which makes their reintegration into the community difficult (ACCA, 2013).
Promoting mental health and the social inclusion of mentally ill individuals are important issues for quality of life (McDaid, 2008). Social inclusion of the mentally ill should be a deliberate effort on the part of the community and the health system.

Reintegration which is a product of recovery is a fundamental right of the mentally ill. Yamin and Rosenthal (2005) are of the view that people are entitled to live and receive care, study and also live with their families and friends in their communities so as to help keep their identities.

Without intervention from the system and individual levels, there is a risk of social isolation for people with mental health problems when they move into their own home (Nilsson, 2004).

Health in its entirety should be regarded as an effort geared towards improving one’s quality of life. Public health work is directed towards promoting good physical health, in part by influencing living conditions and habits. However, it should also provide more support for mental health by encouraging empowerment, self-respect, human dignity and security, in addition to a sense of being respected and acknowledged. In the advanced countries reintegration involves a stepwise process of getting the mentally ill patients back into their communities.

In Ghana however some of the challenges facing reintegration into the community for those with mental disorders from treatment facilities stems from lack of structures put in place by
the health system to provide the needed pathways for the smooth transition from institutionalized care to the community. The ideal is to get the discharged patients into sheltered care or halfway homes, which has a semblance of an ideal home or get them into rehab centers or facilities to help them regain their lost skills or get them to learn new skills to enable them function properly.

1.2 Problem statement
Mental illness has personal, social and economic consequences for patients and family. Consistently the evidence points towards strongly negative attitudes towards people with mental health problems (McDaid, 2008). Negative attitudes towards the mentally ill are not only found among the general public and the media but also amongst mental health professionals (McDaid, 2008). In Ghana, only one out of every one hundred people with mental illness will get the care they need and without treatment, this can lead to social exclusion and poverty for those with the illness and their families, including the adolescents (The Kintampo Project, 2012).

The stage of adolescence comes with a lot of stress which when not handled properly may result in the individual being unable to handle such stress and later becoming mentally ill. Many mental health problems emerge in late childhood and early adolescence (WHO, 2016).

Often times many adolescents who have been treated and discharged from the psychiatric hospital have been abandoned by their families and other caregivers because they feel ashamed to have them home due to stigma. This goes a long way to increase the burden of the disease on these young patients. It has emerged from practitioners at the Pantang
Hospital that one of the challenges the institution faces with reintegrating the mentally ill is the reluctance of relatives to accept them back home. They described instances when relatives give fake phone numbers and addresses to make it difficult for them to be traced when their relatives are discharged (Broaddus, 2013).

The lack of education to the families and communities about patients’ disorders and life after management at the healthcare institution is also a challenge to their reintegration. This is a well-known fact that insufficient public education affects acceptance of the mentally ill back into the community and for rehabilitation (Osei et al., 2011).

Transferring patients to homes in the communities does not automatically ensure reintegration into society. There are a number of barriers to social integration some of which include stigmatizing attitudes of the public, patients’ lack of social skills and difficulty in obtaining a job upon release (Goffman, 1961).

Pantang Hospital has dedicated a ward (Ward 12 or the Vagrant Ward) which is solely for admitting people who have been neglected by family and the community. Some of the readmissions are not as a result of re-emergence of symptoms but as a result of stigma and discrimination from relatives and the community. It also emerged that smaller social networks and less social support were associated with more frequent hospital admissions (Maulik, 2009).

Even though no work or study has been done in this community about the challenges facing the mentally ill towards their reintegration, studies in other parts of Ghana on stigma and discrimination have revealed that people with mental disorders are stigmatized and
discriminated against socially, economically and psychologically (Tawiah, Adongo, & Aikins, 2015).

The purpose of this study was to bridge the knowledge gap on the challenges faced by adolescents within the Madina Metropolitan area in reintegrating back into their communities upon discharge from the psychiatric treatment facilities. It also sought to assess caregivers and community perspectives of the challenges associated with accepting their adolescent relatives back into their homes.

1.3 Research Questions

What are the challenges associated with reintegrating adolescents with mental disorders into the community?

What are the processes involved in reintegrating the adolescent with mental disorders?

What are the experiences of caregivers and their relatives towards reintegration?

What are the health system challenges associated with mental disorders?

Which community and environmental factors influence reintegration?

1.3.1 General objective

To determine factors impeding reintegration of the adolescent with history of mental disorders into the Madina Metropolitan area.
1.3.2 Specific objectives

1. To determine the processes involved in the reintegration of the adolescent with mental disorders.

2. To understand the experiences of patients and caregivers towards their reintegration.

3. To identify health system challenges for reintegration of the adolescents with mental disorders.

4. To identify community and environmental factors that influence reintegration.

1.4 Conceptual framework on Reintegration of the Mentally Ill Adolescent

This study adapted the “Mental Health Promotion Framework of the WHO. Factors” contributing to reintegration (WHO, 2005). This framework represents a public health approach to mental illness prevention and mental health promotion, and addresses determinants of both community and individual mental health. The key social and economic determinants of mental health in the framework are:

1. Social inclusion: Social relationships, involvement in group activities, civic engagement. The elements of the conceptual framework self-acceptance and positive self-esteem leads to clients availing themselves to participate in social activities.

2. Freedom from discrimination and violence at work: Valuing diversity, physical security, self-determination and control of one’s life. Enactment of sound policies and pathways that supports reintegration creates an enabling environment devoid of discrimination and violence against adolescents with mental disorders.
3. Access to economic resources and health: Work, education, housing, and money and healthcare. Having access to these resources is dependent on a mental illness friendly community and a community with adequate knowledge about mental health and mental illness.

4. Policies and pathways to reintegration e.g. halfway homes and laws to punish people who discriminate against people with mental illness.

5. Accommodative health personnel and good family or social support is very necessary for a smooth reintegration and vice versa.
Figure 1 Conceptual framework on Reintegration of the adolescent with mental illness (WHO, 2015)
1.5 Justification

Reintegration of the adolescent with mental illness will remain a challenge if the causes of
the challenge are not addressed at the individual patient level, the family and community
level and at the level of health system or policy.

Mental health has an impact on varied development outcomes and is a basis for social
stability because it serves as a key determinant of well-being and quality of life (WHO,
2010). Given that mental health is an important indicator of human development, issues
regarding stigmatization and discrimination against persons with mental health disabilities
cannot be ignored. The World Health Organization for instance, has linked the stigma and
discrimination associated with mental illness to suffering, disability and poverty (Corrigan,
Watson, & Barr, 2006). This study sought to enquire what the processes involved in
reintegration are and what impediments exist that hinder the smooth reintegration of
adolescents in the La –Nkwantanang Municipality. Patients from different homes are likely
to experience reintegration in different forms. Thus it will be imperative to enquire about
the various experiences of such patients and what accounts for the disparities.

This study findings will also be used to recommend to policy makers to put structures in
place to empower adolescents with mental illness with skills, educate caregivers and the
community and also to introduce transitional or halfway homes to facilitate the re-entry of
these adolescents into their communities.
CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews relevant and current work of scholars in the subject area under study, examine the methodology employed in the various studies which served as a guide for this study and also establish a sound evidence for comparing this study finding’s. The literature is organized under the specific objectives of the study.

2.1 Mental Illness

There are currently 450 million people with mental illness worldwide, and one in four people will develop a mental illness in their lifetime (WHO, 2001). Mental illness comprises depression, anxiety, schizophrenia, affective disorders, and substance misuse. Mental health is not merely the absence of illness, and is defined by the World Health Organization as an individual’s ability, to realize their capabilities, cope with the normal stresses of life, work productively and fruitfully, and contribute to his or her community” (WHO, 2005)

Mental illness negatively impacts on social cohesiveness, economic productivity and poverty reduction (Currat & Francisco, 2004). At all levels of society, persons with mental illness may face discrimination (Thara, & Srinivasan, 2000). Many who have recovered from a mental illness, known as ‘survivors’, have recently prompted a movement in mental health, focused on recovery, that rejects the traditional ‘medical model’ of psychiatry
(Cohen, 2006). Rather, many survivors view mental illness as a ‘temporary crisis’ as opposed to a physical disease,

They believe that mental illness is an emotional/behavioral/biological and spiritual manifestation of a complex interplay of social, emotional and cultural stressors (Neugeboren, 1999).

2.2 Reintegration and its processes

Reintegration and its processes is a sub theme of policies and pathways of reintegration which is an element of the conceptual framework of this study.

Reintegration is that part of recovery which allows people who have had to leave their homes and community to a hospital or rehabilitation center for treatment to assimilate into daily lives and become responsible for themselves (Farkus).

According to Yasui and Berven (2009) reintegration of the mentally ill and all disabled persons, is a right and should be a product of self-help, peer support and the provision of other services such as housing, jobs and other professional services.

The degree of acceptability of persons with mental disorders back into the community does not really have to be structured in all cases. Reintegration should always be tailor designed to suit the individual cases and it should be based on the needs of the patient. The ability of these individuals to function properly depends largely on the social support systems they have. Below are some key determinants of reintegration.
2.2.1 Psychosocial rehabilitation

Psychosocial rehabilitation is the process of restoring community functioning and well-being for a person who has a mental illness. This is important for reintegration, as a person who just had a psychotic episode may have feelings of loss of control over their life, and loss of their identity and self-worth. Adding to this involuntary hospitalization and treatments, an individual becomes even more overwhelmed by the loss of control over his/her life. As such, ideally, psychosocial rehabilitation should occur in settings which are not based in a hospital, clinic, or mental health centre. Fellowship with others who have psychosis can help to deal with the social isolation and can help to start the process of reintegration. If this is successful, then the disordered person no longer identifies himself as disordered; rather, they identify as a healthy person again.

2.2.2 Academic and vocational rehabilitation

Acquiring good education and building skills to get income-producing work is a very important part of reintegration into society. Nothing gives you more meaning, identity, and self-worth than having a job. Having a job also instills structure into a person’s day, which provides further stability. But the most stability is gained from earning an income from an honest day’s work, and providing for you and your family. Getting good education and skills are key components to reintegration into society.

2.2.3 Psychoeducation

It is important that the person with psychosis is given accurate and evidenced-based information regarding their illness and their prognosis. They need to know what to expect with the future course of their illness, what can trigger another psychotic episode, symptoms to look for, and the administration of their medication(s). These education should include
empowering them with information on the hostile nature of the community towards people
with any form of mental illness.

2.2.4 Family support

Family and the caretakers of those who have psychosis are important to the reintegration of
the disordered person back into society. Family and caretakers are the natural supports in
the community which a disordered person can rely upon. But this can be stressful for them,
given the consequences of not providing adequate support for the disordered. As such,
family and caretakers also need psychoeducation, guidance, and support on how to help the
person with mental illness reintegrate back into society. In a series of case reports in India
by Chakraborti and Gajendragad (2015), it emerged that when community participation in
the care of mentally ill people is spontaneous and forthcoming reintegration becomes
successful. They cited a case of a 25-year-old who was admitted on court order basis or
reception order of a Metropolitan Magistrate. Her husband had deserted her but the patient
who had shown significant recovery within 4 months was able to give an address of her
brother. The brother was contacted and he went for her from the hospital and she has since
been reintegrated with her family (Chakraborti et al 2015). The families of people with
mental disorders play a very vital role in deciding what care their relatives receive, thus
enhancing their quality of care (Mangan, 1994). The supportive role of these supports also
help to reduce the rate of relapse (Ostman et al, 2000).

2.2.5 Physical health wellness

When people are disconnected from society, they also lose interest in their own physical
health. Additionally, medical morbidity and mortality are elevated in schizophrenia
compared to the general population (Goff et al., 2005). This is due to the higher rates of
smoking, obesity, and metabolic syndrome in schizophrenia. Obesity is exacerbated by the lack of physical activity, while metabolic syndrome seems to be associated with taking atypical antipsychotics. So a cornerstone of reintegration into society is keeping healthy.

### 2.3 Definition of Stigma and Discrimination

Goffman (1963), defined stigma as an attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted discounted one. In Goffman’s (1963) view stigma commonly results from a transformation of the body, blemish of the individual’s character or membership of a despised group.

Chapple (2004) also defines stigma as existing when a person is identified by a label that sets the person apart and links the person to undesirable stereotypes that result in unfair treatment and discrimination.

Stigma is the social devaluation of a person because of personal attribute leading to an experience of sense of shame, disgrace and social isolation (Thara et al, 2000). Discrimination is the treatment or consideration of, or making a distinction in favor of or against, a person or thing based on the group, class, or category to which that person or thing belongs rather than on individual merit. Stigma and discrimination are attitudinal in nature and it is experienced by mentally ill persons worldwide. It’s an attitude displayed towards the mentally underprivileged by the community and some health professionals (McDaid, 2012). It has become a human rights issue in most developed and developing countries and has seen many civil society groups call on policy makers to make it illegal to discriminate against persons with mental illness.
Stigma and discrimination against mentally ill persons have the tendency to make these persons stigmatize themselves by internalizing the feeling that they are less valued and thus leads to a low self-esteem. Low self-esteem leads to social isolation and avoidance of anything that has to do with the public. Link (1987) has it that self-stigma and the fear of rejection by others may lead persons to not pursuing life opportunities for themselves. Stigmatization may sometimes be more socially inhibiting than the disease itself leading to low self-esteem, social isolation and non-compliance with medication (Gerlach, 2004). A study in Lithuania, there were pharmacists who were found to be dispensing medication to patients with severe mental illness that was past its expiry date.

2.4 Experience of patients and caregivers towards reintegration

The burden of mental illness is not always experienced by the sufferer of the condition alone but the family as well. The social, economic and psychological stress of having a mentally ill person in the family becomes very devastating for the larger family as a whole. It is due to these challenges that most families don’t really associate themselves with their discharged relatives. This explains the role of the community factors or community with a positive attitude towards mental illness in the mental health conceptual framework.

Patients have always been shown scorn and rejection from friends and family members during times of hospitalization and discharge. People with mental illness are sometimes left to fend for themselves during admissions at the hospital, even though a strong social support is an integral part of their recovery and reintegration.’

Quality relationship is a better predictor of good health than quantity of relationships although both are important (Ozbay et al., 2007). In Ghana, peoples’ attitude towards
persons with mental illness stems from the fact that they are seen as dangerous and spiritually unclean (Gureje & Alem, 2009; Read et al, 2009).

Many Ghanaians show negative attitudes towards the adolescent with mental illness, they on many occasions don’t want to have anything to do with the word ‘mental’. This was realized by Dr. Yaw Osei when he was establishing a psychiatric unit in Komfo Anokye Teaching Hospital (Laugharne, Burns 1999). Most of the indigenes in Kumasi considered mental illness a taboo. He resorted to calling the unit ‘Headache Clinic’ to escape the wrath of the indigenes (Laugharne, Burns 1999). Stigma, discrimination and other negative attitudes shown towards sick persons with mental illness and their families renders them incapable of reintegrating into society and to function well. Kapungwe et al (2010) noted that discrimination and stigmatization against persons suffering from mental disorders hinders their ability to reintegrate into society and recover from the illness, due to frequent personal harassment, isolation and exclusion they experience.

2.5 Health system challenges of reintegration of the adolescents with mental disorders

Health systems are very important in the treatment, recovery and reintegration of persons with mental illness. They play a major role in getting symptoms to subside and enable these clients to function properly with little or no symptoms. Ideally, clients who are discharged from mental hospitals are supposed to be seen at home periodically by community psychiatric nurses and community mental health officers to assess their wellbeing and counsel them when the need be.
These services are sometimes not readily available to such patients because of the acts of stigma and discrimination meted out to these clients by the health professionals. In a study of psychiatrists, nurses and psychologists in Switzerland, it was found that mental health professionals did not differ from the general public on their desired social distance from individuals with mental health conditions (Nordt et al., 2006). Policies also go a long way to either protect people with mental illness or stigmatize or discriminate against them (Ozbay et al., 2007). Herek et al., (2003), contend that when a disease is stigmatized, public health policy can help to protect those who are ill from popular prejudice or it can promote discrimination against them.

Studies also show that individuals seeking care in primary healthcare facilities may not receive equivalent care compared to non-mental patients once their status is known (Desai et al., 2002). Gasman et al. (2001) have also stated that health professionals may not provide adequate intervention, early detection or community referral options for individuals with mental and behavioral disorders because of their own stigmatizing beliefs and personal histories. The attitudes discussed above have the tendency to prevent the clients from seeking mental healthcare and thus creating a barrier towards reintegration.

It is widely expected that psychiatrist should be accommodative and accept mentally ill people into the community but literature states otherwise. Lauber and his colleagues, found that psychiatrists compared with the general population were more willing to accept mental health facilities in the community, but were as socially distant to mentally ill people as the general population (Lauber, Anthony, Ajdacic-Gross, & Rössler, 2004).
2.6 Community Attitudes towards the mentally ill

The attitude of the people we live with when we are disabled or have any debilitating illness, goes a long way to determine how fast we recover from disability. Adolescents with mental illness develop low self-esteem due to societal attitude towards them because they are mentally ill. Most often it’s attributed to lack of knowledge of their condition and also the misconceptions about how dangerous they are. These misconceptions breed fear amongst the community members and neighbors and degenerates to stigma. Wolfe et al (1996) revealed that people who have no knowledge of the mental illness of adolescents tend to shun their company (Wolfe, Pathare, Jeff & Craig, 1996).

Reintegration is largely difficult to carry out when the community in which the adolescents with mental illness live display negative attitudes towards them based on the misconceptions they have about the causes of mental illness. Ukpong and Bs (2010) revealed that despite peoples’ knowledge about the genetic and psychological causes of mental illness in Nigeria, they still associate mental illness as a punishment from the lesser gods or divine punishment or being caused by witches (Ukpong & Bs, 2010). Community attitudes and beliefs regarding mental disorders and the mentally ill influence the help seeking behavior of adolescents. Ignorance about the advances in the diagnosis and management of mental disorders and mental illness can only be studied with the availability of effective treatment and the fear of stigmatization may prevent people with mental disorders from seeking professional help (Hugo et al, 2003).
CHAPTER THREE
METHODS

3.0 Introduction
This chapter enumerates how the study was conducted in achieving the research objectives. It describes briefly the profile of the study area, the study type/design, study population, sampling techniques, sample frame and size, data collection tools and techniques, data processing and analysis, ethical consideration and the study limitation. The totality of these is the methodology of the study.

3.1 Study design
A qualitative research method and a case study design was used to determine the challenges of reintegration of the adolescent with mental disorder in Madina. A qualitative research was helpful because it helped to explain the phenomena of reintegration and also the lived experiences of participants and also to understand how people behave the way they do. Generally, reflection on the lived experiences is re-collective because it is a reflection on experience that had passed or lived through (van Manen, 1990). This helped get answers to my research questions concerning the challenges facing adolescents with mental illness with regards to reintegration. It also assisted in bringing to the fore, the behavior and beliefs as well as understanding the context of people’s experiences (Hemink, Hutter, Bailey, 2010).

3.2 Study location-
The study was done at Pantang, Madina and Danfa all in the La-Nkwantanang Madina Municipality of the Greater Accra Region. La-Nkwantanang Madina comprises people of various ethnic backgrounds.
It’s in this municipality that one of Ghana’s three Psychiatric Hospitals, Pantang Psychiatric Hospital is located. It shares borders with Adenta and the University of Ghana, Legon. Its inhabitants are mostly traders and civil servants. La-Nkwantanang Madina is a cosmopolitan society with people from various ethnic groups. They speak different Ghanaian dialects. It has a population of 137,162 inhabitants.

Figure 2 Map of Madina in the La–Nkwantanang Municipality

3.3 Study propositions

The dependent variable is reintegration.

The following propositions can be made from the study:

- Attitudes of the community and family members affects reintegration of the mentally ill

- Attitudes of the health professionals has an impact on the reintegration of the adolescent with mental disorders

- Stigma and discrimination and has a negative impact on the reintegration of adolescents

- Attitude towards self.
3.4 Study Participants

Purposive sampling method was used to select 19 care givers who were available during the period of the study, 12 patients, 10 health professionals and 9 community members. Purposive sampling method, a non-probability sampling strategy ensures the appropriateness of sampling and the adequacy of information gathered while saving time (Fossey, Harvey, McDermott & Davidson, 2002). The caregivers were relatives of the patients who have been discharged and are coming for review. The 9 community members were selected based on their proximity to the clients. Some of these community members have been selling wares and food within the Pantang community since the inception of the hospital. Some also live in the same neighborhood with the clients. The clients or patients who were coming for review were selected with the help of the OPD staff. The key informants interviewed were nurses including the In-service Coordinator of Pantang Hospital, The former and longest serving Chief Psychiatrist; and one of the Psychiatrists at Pantang Psychiatric Hospital.

3.5 Data collection technique and instrument

The data from the clients was collected using an open ended interview guide based on a modified Community Attitude towards Mental Illness (CAMI) questionnaire. The questionnaire (CAMI) is designed by WHO to elicit people’s experiences and also their perception of mental illness. The CAMI semi structured interview was to ascertain the client’s perception on the processes of reintegration, experience at the health facility and with community members. Focus group discussion was held for five (5) clients on one of the wards (newly readmitted clients) a focus group is a group discussion on a particular
topic organized for research purposes. This discussion is guided, monitored and recorded by a researcher (sometimes called a moderator or facilitator), (Kitzinger, 1994). Key informant interviews were conducted with the health professionals of reintegration on the concept reintegration, stigma and discrimination. A data extraction form will also be used to extract data collected during the study. The consent and ascent of each respondent was sought before data was collected.

3.6 Data processing

Records of the number of the data extraction forms sent out to the field and the number received was kept to ensure that all forms sent out were returned. Data was processed by a preliminary clean-up of the data extraction forms and checked for completeness and appropriateness of all filled in information. English, Twi and Ga as well as Hausa were the medium of communication during the study. The information extracted was transcribed, coded and entered into NVIVO for analysis, editing to identify missing data, invalid or inconsistent entries were clarified.

3.7 Data analysis

The qualitative data was processed using NVIVO. The Key informant interview and the focus group discussion were both transcribed and coded with themes that emerged during data collection duly identified and analyzed using thematic analysis. Braun and Clarke (2006) define thematic analysis as: “A method for identifying, analyzing and reporting patterns within data.
3.8 Ethical clearance

Ethical and institutional approval was sought from the Ghana Health Service Ethical review committee, Mental Health Authority and Pantang Hospital. This was done through the School of Public Health after a proposal for ethical clearance was submitted and approved respectively.

An introductory letter was collected from the school to the two institutions. The objective of the study was explained to them and in the case of adults their consent was sought. With regard to the adolescents who were yet to be 18 years their rights to voluntary (i.e without coercion) participation, privacy, accent from a guardian and confidentiality of the study was explained to them in details before their participation.

3.9 Limitations of the Study

Most studies have limitations and this study is no exception. The number of clients and caregivers that was proposed to be interviewed was not achieved because the attendance rate during the period of the study had reduced. The findings of the study even though represents the experiences of the people in the study area may not be representative of other clients and caregivers from another jurisdiction.
CHAPTER FOUR

ANALYSIS OF FINDINGS

4.0 Introduction

The aim of the study was to determine factors impeding reintegration of the adolescent with history of mental disorders into the Madina Metropolitan area. This chapter presents the data collected. The general/emerging themes or pre-determined descriptive categories below mainly emerged from the interviews conducted and are validated by direct quotes from interview transcripts to verify their authenticity. The sub-themes were also derived from the data after an exhaustive reading of the interview transcripts. Furthermore, some participants’ responses to interview questions often addressed more than one theme. In those cases, the interview data are described where they appear to fit more logically.
<table>
<thead>
<tr>
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Table 4.1 above shows the distribution and characteristics of participants involved in this study. There were 25 (50%) males and 25 (50%) females purposively selected to meet the objectives of the study. They comprised health workers, care givers, clients and the members of the community from which some of these clients live. Some of these community members are self employed (traders). Respondents were from the following tribes Ewe, Akan, Ga, Wala,

4.1 Reintegration of adolescents with mental disorders

Data is presented under the objectives of the study, which include the processes involved in the reintegration of the adolescent with mental illness into the community. Respondents mentioned several supports and services that could promote successful community reintegration of adolescents with mental disorders. These included: Community-assisted psychiatric nurse services, community support groups, and public education drives to battle stigma.

Reintegration and its processes:

The process of reintegration involves human resource, infrastructure and material resources. In their response some of the participants shared their experiences with regards to the above resources towards their reintegration or otherwise or the role such resources play in reintegrating the adolescent with mental disorders.

Respondents found community-assisted psychiatric nurse services to be very valuable for adolescents with mental disorders:
“We have the CPNs, so as soon as you have admission this people will come and visit the patient preparing the patients for discharge. They will consult the family and find where they live so that when they are well the CPNs will go to the families and tell them that the person’s condition has improved and give information on how to take care of them when they are reintegrated into the community. There should be an intermediary between the families and the hospital, in some places there are social workers but in Ghana we don’t have many social workers so we use the trained CPNs based in the institutions to play the role of informing and following up on the patients.” (Health Professional I)

“Having adolescents in the community hinges on whether client is schooling or engaged in a trade, the community psychiatric nurses normally follow up on the cases, help clients to reintegrate into the community, go about their normal activities and put them on medications to get them sound. It helps so it should continue since we can’t keep them in the hospital forever” (Health Professional VII)

In most cases, work or school colleagues often express apprehension in accepting a person with history of mental disorder back to the surrounding. Therefore, it is anticipated that an approach-designed gradual return to work, to expedite the progressive reintegration of the individual to his or her work, was an option favored by respondents. Respondents saw this as a way to ease the impact of returning to work on their health. Analysis of the interviews allowed for further understanding of the reintegration process for adolescents with mental disorders to gradually adapt to the work or school environment with ease. This study found that gradual return to work can be effective only if the work or school context is one that is accommodative of people with disabilities including people returning from mental hospital.
The gradual return to school or work is meaningful if workload and responsibilities also increase gradually:

“The normal procedure we use when a patient is discharged is we don’t advice that they go back to school or work immediately....... you are given a period of time to come for review for us to know your improvement after you went home, it depends on your progress at home that will make us recommend that you start work or school or whatever it is that you were previously doing or engaged in. Once the patient is stable in mind there is no need staying home if not he or she will become a burden....... you can work if your condition is a chronic one but once you are back on your feet we have a period of relapse and remission. During your period of relapse you can come for treatment and when you are stable you go back into the community and work because you have to be resourceful but when you become a burden, boredom may lead to a relapse so getting yourself involved in activities will help.” (Health Professional IV)

“I do recommend that........it’s the best. It prevents the person from losing his or her worth or substance and makes him or her feel much better. If you are sick of diabetes you get treated, you go back into the community and back to work so if I am treated of schizophrenia, I recover and have my medications, I can be at home and take my medication unless the mental illness has actually affected my psychological functioning to some extent then it will equally not be advisable. However the person can still go to work and be redeployed by giving him another task to do at the same workplace but shouldn’t lose his or her work. People have physical illnesses and may not be able to withstand some
stresses at work and when there is some redeployment they make them do other things ........why can’t it be done for the mentally ill?”(Health Professional V)

However, since the work or school environments are mostly engrossed in performance-oriented targets, it is normally difficult for colleagues and superiors to offer genuine support for reintegration. During the interview some respondents noted:

“Yes if a patient is working and he/she is sacked because of mental illness, the stress of being sacked alone will even make it difficult for the person. For instance, a student at SHS is made to stop school he or she will be denied good education. It demands that the school will be educated about mental illness so that they will understand the clients and accept them back to school.”(Health Professional III).

Community and family support services are also key in the processes of reintegration. Most participants agreed that the right thing is to reintegrate these adolescents into the community. It was also realized during the interview that most of these adolescents tend to rebel due to stigmatization. Community support will be necessary to maintain stability between patients and family, to provide help at times of crisis and prevent deterioration of their condition. These support can ensure that the necessary help required in the case of unexpected events are available. However, the reality is, things are not smooth for these adolescents recovering from a mental disorder. The clients and family members in the reintegration process face a lot of hurdles and difficulties:

“Discharging mentally ill into the community is the right thing. It’s good that after they have been treated they go back into the community and engage or continue with what they
were doing before unfortunately they fell sick and were brought to the hospital for treatment.”(Health Professional VI).

“I will not really recommend that they should be managed in an institution, it is better to manage them in the community and their homes or close to where they live, unless they have some behavioral problems ........... then you will be forced to be recommending a therapeutic community for them so that they will be counseled on how to learn certain skills and learn from other peers so that they can change their behavior. Most of these adolescents have problems, the major ones include identity problems, difficulties in dealing with their families, once they are growing up they will like to rebel and the families are not ready for them. They need some kind of support in a way of counseling and some kind of management, you cannot usually treat adolescents in isolation, the families will need separate support, separate understanding and then you will have to see them at work with their children. They are a special group of patients that need some special attention but I will prefer to manage them in the community rather than in the larger institution unless they have behavioral problems like addiction, there you will want to get them somewhere to manage before sending them back to their homes.”(Health Professional VI)

Most participants noted that community support systems should focus on educating family and community members on the need for changing negative perceptions about people with mental illness within general society and within the broader disability community. Lack of information about the conditions of these adolescents and the misconception that mental illness is not curable impedes on the smooth processes of reintegrating them back into the
society. Additionally, the school support system should ensure that schools are enlightened about mental illness to reduce stigmatization. Some respondents discussed this further;

“*Oh yes they should, they come from the community to the hospital they have spent some time in the hospital they have been managed and they are all right so if we keep them here, how long is that going to take? Are they going to be here for good? So if we are able to educate the person and he is able to take medications as prescribed, they will do well. The person has a family so if you keep the patient here how is he going to take care of the family? Lack of education makes it difficult for them to reintegrate into the community. Lack of information about the patient to the family makes it difficult to accept their relatives into their community. There are signs and symptoms and the things they have to do to avoid a relapse. With this information they will understand and take their medications as prescribed so they shouldn’t be kept for long in the hospital. Education on how to cope and live with family members and the community should be given to the patients too*. *(Health Professional III)*.

“*Adolescents who are discharged into the community have a bit of challenges in terms of them being accepted. Looking at the immediate family of the patient some of them do not have substantial ideas of the condition the client is suffering from. We all know literally madness comes with aggression the immediate family has some fear in relating to the patient when they are brought back home with the idea that they might hurt them. The same thing applies to the neighborhood, the people that live with them and their friends wouldn’t know how to relate to them again when they get home. It applies to the school as well, when the students get to know you have suffered mental illness, it becomes a problem*
maintaining your friends: some sort of fear. They don’t have much knowledge of the condition so it becomes a challenge for the clients.” (Health Professional IV).

“Anyway with their stay in the community, they face quite some challenges. It’s a great idea looking at mentally challenged adolescents to reintegrate into the community. However, people that live within the community get to realize or know their behavior before they go for mental health treatment, therefore, find it difficult to accept them. They are somehow curious watching out their behavior to see whether they will do something unusual to conclude that ah! He or she is not cured..........there is something left so most of the time even if they are well without any mental problem people are always looking for something and sometimes there are some of the challenges that they face with their own colleagues and some teachers find it difficult to accept. I had time to talk to some teachers, friends and relatives and they ask ‘are you sure our relative is well?’ So we explain to them that there is nothing currently wrong with their relative, the person has received treatment and he is well. So sometimes it makes full integration difficult however some of them have very supportive families that stand with them and some also have families that have given up on them.” (Health Professional V).

Finally, a respondent proposed community-based care to institutional care. The institutionalized system of mental healthcare usually burdens the state in terms of cost. Hence, apart from the many benefits of treating these adolescent in the community, this is a form of cost-sharing where the family also tend to bear some cost of treatment.

“Yes majority of them. Now what we proposed was that we should try and manage psychiatric patients more in the community than in the psychiatric institutions so we are
frowning on the institutional care .... This has a lot of positive effects in the sense that if you compared how we had our asylum concept, people were brought here forcibly and they’ve become the properties of the state and they will stay until you want them to go home. It is very expensive to practice institutional care, the community care is cost sharing we’ve intended that, you don’t leave the patient to the family alone but you will also train some who will support them in the homes and also the community and you make facilities available in the community so that people can walk in relatively than travelling long distances to be admitted into psychiatric hospitals. ............” (Health Professional I).

4.2 Patients and caregivers experience towards reintegration

These section chronicles the lived experiences of patients or clients and their care givers or relatives with regards to reintegration into the community. Their responses are captured under two emerging sub themes experience towards reintegration and care giving respectively.

4.2.1 Experience towards reintegration

Knowledge of condition

Some clients have little or no knowledge about their disease condition and what it takes to get treated and regain functionality. Some patients also expressed interest in receiving special care and having more insight about their condition.

“Yes, I would like to know more about my condition” (Patient 4)

“Yes I will like to talk to someone who has knowledge of my condition” (Patient 2)
History of Mental Illness

This sub theme sought to enquire from respondents how much information they had about their mental illness. When they were diagnosed and made to start medications and therapy.

Participants identified some plausible causes of their mental illness……

“I think that it is my intake of marijuana and I sometimes think it is spiritual”

“It is biological” (Patient 1).

“No, I have no idea of the cause of my condition” (Patient 2).

“I think it is biological. I have depression and emotional issues” (Patient 3).

Social Isolation and Low Self-esteem

Some participants described social isolation and low self-esteem as a common experience. Participants saw multiple and interrelated reasons for this isolation and low self-esteem including; mental illness related stigma and lack of financial resources. Participants described how stigma related to mental disorders affected their social interaction with others:

“Yes, I feel I have lost everything........I do not get closer to people because I am naturally reserved and not all members of the community get close to me” (Patient 1)

“Yes, some of my friends and colleagues acted when I visited them, sometimes I feel sad, lonely and rejected due to the behavior of my friends.” (Patient 3)
However, others were able to adapt and relate more to others. Particularly, all participants were happy with their experience at health facilities and expressed satisfaction with services received.

“I felt bad at first but I never felt worthless……… I relate very well to the community and my family still shows me love. I socialize very well with my friends. I visit them and they also visit me. The hospital staff do not disclose my condition to people. It is rather my family who tell people about my condition. One client however, calls me names (Patient 2).

“No health professional tagged me with derogatory names during my stay in the Hospital…… I have never encountered any client who has. We come for treatment and sometimes have conversations whiles waiting” (Patient 1).

“I am treated with respect…… the nurses are polite and have made my diagnosis confidential. We are involved in chores like washing, sweeping, scrubbing” (Patient 2).

Availability of social opportunities and family support for adolescents were salient in light of the importance of social participation for avoiding institutionalization. Participants were able to join in religious activities without being discriminated against:

“I get enough support from my family. I don’t feel embarrassed. I do not go to church frequently because I prefer to be at home and read the bible” (Patient 1).

“I visit the mosque regularly…… I get partial support from my family because they take care of my healthcare bills but not my upkeep” (Patient 2).

“Yes, I am able to go to church but not frequently.” (Patient 3).

“I do not feel embarrassed going to church and people don’t call me names.” (Patient 4).
Stigmatization

Stigmatization may sometimes be more socially inhibiting than the disease itself. This can lead to social isolation and affect patient’s self-esteem:

“Yes, people give negative comments but it does not worry me” (Patient 1).

“No, I do not get negative remarks” (Patient 2).

“Yes, I get negative remarks and I get disappointed” (Patient 3).

4.2.2 Caregiving

Caregivers expressed their opinion on some experiences they go through caring for adolescents with mental disorder:

“No I have never faced any sort of embarrassment...honestly, I have never been stigmatized and I don’t know if anyone has experienced that.” (Caregiver 1).

“I have spoken to my client several times about working but I feel sometimes the drug makes him weak...he wishes he was working but due to the drug intake he is unable to be productive at work. My client has once been admitted, but he prefers to be treated at home. He is comfortable in the house...I think it is the best form of treatment.”(Caregiver 2).

“Nobody has blamed anybody or blamed us for what he is going through...the health professionals are surprised the way we have made it our responsibility to take care of him. He is a member of my church. I personally brought him because my bishop asked me to. So, I am in charge of his welfare and due to my social work background he’s asked me to be

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responsible. So I brought him to one of the empty apartments one Sunday after church, took
care of him and gave him his medicine. We buy his clothing and we take care of everything,
He is not currently working, even though, he is a constructor (mason) but he cannot work
or do anything due to his condition.” (Caregiver 2)

4.3 Health system challenges for reintegration of adolescents with mental disorders

Mental health system problems can be embedded in interconnected contributory factors.
The problems in the health system include lack of major capital investments to improve
physical conditions of institutions, lack of community-based support systems to reintegrate
people with mental disabilities back into society and lack of human resources to cater for
people with mental health disorders. From this study, it was revealed that mental health
workers are not only stigmatized by the community, but also by their colleague health
workers in other disciplines of the health sector. Other health workers also explained how
they are stigmatized by clients at times. Below are some quotes from the interview:

“Yes, sometimes we do, nurses who work in Psychiatry are stigmatized by their own
colleagues who work in different fields but it’s more tolerable, we understand where they
are coming from, you being called names. I was schooling in Legon, my colleagues who
were aware of my profession as a psychiatric nurse whenever they see a mentally
challenged person they will tell you „these are some of your people go and grab them and
treat them.” (Health Professional VII).

“Yes, plenty even our colleagues they don’t see why we should be taking care of psychiatric
patients. People in the community see you and they think that you need to be like them ,you
need to experience psychiatric conditions to be able to understand a psychiatric patient so as they see you as somebody who has some special powers or someone who has mental illness that’s why you can relate to them. When it comes to asking for resources to manage the psychiatric patients they don’t see the need for government spending money on the mentally ill, they feel its waste of resources since there are so many other demands like childhood diseases, non-communicable diseases etc. Personally, sometimes my children go to school and they are told that your father is a psychiatrist, we saw him on TV, his hair looks like that of a patient. Working in this environment as a mental health professional usually stigmatizes you because whatever they think about the mentally ill also applies to you. I attended a function somewhere and they introduced me as mad doctor. Now, we know that is the level that we have gotten to but gradually things are changing due to education. But it hasn’t affected my work, what it does is that it discourages the new ones from volunteering to be trained.” (Health Professional VIII).

“I met a client at ward 8 doing something, I asked her to stop and then she told me that I am also mentally ill. Her reason was that, if I am not mentally ill then I should be working at Korle – Bu or any other place, why here? So factually, the patient even thinks that we are like them that is why we are able to take care of them and in the same way, if you tell someone that you work at Pantang Hospital the person will look at you twice, you then ask yourself why? Oh even a staff at Korle Bu asked me why even our own colleagues who are general nurses look down upon us, they think we behave like our patients, but what you ask yourself is that, if I am like my patient how am I able to take care of them...............” (Health Professional III).
However, other health workers feel, these adolescent clients need their services more since they were more vulnerable. Others also reiterated their love for the profession.

“No, I have never thought of it because over time I have come to realize that you need someone to take care of the vulnerable.......... the training I’ve had has given me a better insight into who a human being is, today you are normal, tomorrow you are abnormal. What happens if I am mentally ill? That is what keeps me going. When I see people come in a bad state then later see them in a good state I feel better.” (Health Professional VI).

Personally, I think I am enjoying what I am doing, helping to stabilize clients in their bad state, I prefer this.” (Health Professional VII).

No! Psychiatry helps me to develop my skills and to cope with any kind of challenge that comes my way because I know that there is a thin line between wellness and mental illness and crossing over is very easy but recovery is very difficult and it helps me face certain challenges.” (Health Professional III).

“I will still have gone for mental health nursing, the specialty makes you know the human being, your going and coming and growing up with life issues depends on the mind. Once the mind is off that’s the end of you, so doing psychiatry opens up the mind of the professional, it helps manage life’s stresses, it gives you fore knowledge of what life really is unlike the physical conditions , when treated its gone or chronic taking medications et..” (Health Professional IV).
4.4 Community and Environmental factors that influence reintegration

Community reintegration after mental illness is difficult for many adolescents. Returning to familiar home environment can be recognized as key in recovery and a major source of motivation for adolescents with mental disorder. However, community stigmatization could trigger relapse. While other participants were stigmatized, one other participant expressed the desire to change his environment due to the unbearable nature of the stigma.

“Yes, some of them call me names” (Patient 1).

“No, they don’t call me names even though some of them know of my situation” (Patient 2).

“I would like to change my environment after I’m discharged but the economic situation will affect it” (Patient 3).

The attitude of community members or neighbours of adolescents with mental illness more often than not is based on fear and insecurity because of the behaviour they witnessed before the client was taken out of the environment.

This respondent sounded very restrictive in her response to the question of whether she will be comfortable living as a neighbour to a person with a past history of mental illness.

“No, please we have seen how such people react, I will not like to be closer to them because they are dangerous to even the people who treat them, how much more me an ordinary person” (community member 1).

To the question of how they will feel if a mental hospital is to be sited within the community a young man answered with this answer:
‘I wouldn’t mind once they will not be allowed to come out and a long wall should be built so they don’t escape and come to town to harm innocent people’’—(community member 2)

In seeking to find out the community members opinion about what should be done to people who show erratic and abnormal behaviour, this was the response given:

‘The person should be sent to the asylum and treated. That is where we have trained personnel who can face them when they become very uncontrollable (Community member 4).

Will you like to marry a person who has ever being treated of mental illness or from a family with a person who has ever suffered from a mental illness? That was one of the questions posed to the community members during one of our home visits to a client’s neighbourhood.

‘no please she said I once watched a TV programme and the resource person said mental illness runs in the family so I won’t allow any of my family members to marry from any family with a mentally ill person’.—(community member 4).

The response below is to a question about community treatment and institutionalized care.

‘The mentally ill if they are not very violent I think can be treated in the home because when they live with the family and see all the positive things that are done, they will copy those positive behaviours. I think that within the home that is where true healing takes place.’—(Community member 5).
4.5 Summary of the Chapter

The findings of this study have highlighted the processes involved in reintegration of the adolescent with mental illness. It brought to fore the role played by the family, the client and the health workers as well as the challenges associated with the process of ensuring the client fits into the community from which he was before being admitted to the psychiatric hospital. This is consistent with the objective of identifying what the process of reintegration was.

Relatives and clients also shared their lived experiences towards reintegration. Some of their experiences included stigma and discrimination from family and friends, as well as community. The challenges of reintegration was not limited only to the clients and caregivers but also to the professionals who are helping to rehabilitate and reintegrate the adolescents.

These findings are linked to the objectives of identifying the challenges of caregivers, clients and the health system respectively towards reintegration.

The next chapter will be the discussion of the findings and how they relate or otherwise with the objectives of the study.
CHAPTER FIVE

DISCUSSION

5.0 Introduction

This study shed important light on the support and barriers that impede the reintegration of adolescents with mental illness into the community. The use of qualitative research approach in this study allowed a detailed understanding of complex phenomena associated with reintegration into the community after suffering from a mental disorder. Findings of this study corroborates what has been previously documented in literature.

5.1 The process of reintegration

This study provides a glimpse of the lives of caregivers, health professionals and adolescents with mental illness at different stages of their involvement in reintegrating adolescents with mental illness into the community. The study found various facilitators and barriers at different levels of the mental health system regarding how adolescents with mental illness can be reintegrated into the community. A study found that, the paths in mental health are not straight, complex and often the factors that facilitate positive treatment for the youth may also act as barriers in different circumstances (Boydell et al., 2006). Similar to previous studies, this study highlights the importance of adolescents with mental disorders being reintegrated into the community (Patel et al., 2007).

This study shows the important role of Community Psychiatric Nurses in reintegrating adolescents back into the community. There’s the need for constant training, motivation and improved incentives to attract more mental health professionals and subsequently improvement on the quality of care. Waidman et al. (2012), argued that antecedent factors account for the inefficient care by health professionals for patients with mental disorders.
such as the deficiency in knowledge, the lack of updating and training in the area, exhausting working hours, insufficient pay and excessive responsibilities. They further postulated that beside these factors, the lack of professional identification with the area of mental health and a lack of ethics deserves to be highlighted to improve the quality of care provided by health professionals.

5.2 Patient and caregiver experiences towards reintegration

Being labeled with a psychiatric disability can result in rejection from friends and family. This rejection perhaps contributes to the gradual distancing from established social networks. Ironically, participants stated that though their family members were supportive, community stigmatization was still a barrier to reintegration of adolescents into the community. Families are crucial in protecting the rights and needs of persons with severe mental illness. They play a critical role in ensuring persons with severe mental illness reintegrate and quickly adapt to the environment. Family involvement is shown to enhance the quality of life of persons with severe mental illness and reduce the risk of relapse (Mangan, 1994).

Regarding reintegration into workplaces and educational settings, this study’s finding is consistent with the inferences of Corrigan, Larson, and Kuwabara (2007), on the campaign of stigma-reduction education, as well as assistance and programming for individuals with mental illness entering workplace settings, such as supported employment. This study also highlights the need for the provision of training to teachers and school counselors so that they can help in the reintegration, early identification and management of behavioral and emotional changes among adolescents. A review by Lindsay et al., (2015), suggested the
need for more comprehensive interventions to help link rehabilitation clinicians, educators, adolescents, and families. Studies have recently illustrated the need for mental health professionals to deliberate on barriers impacting successful adolescents’ transition including academic, social, and emotional factors once an adolescent returns to the school environment (Clemens et al., 2010; Gillian et al, 2014). Previous studies highlight the importance of educational support services for children and adolescents with mental disorders who were unable to attend school due to their condition (Abbott-Chapman, 2013; Bond, 2007; Hancock, 2013). Education support services delivered by hospital or community based teachers either through one-on-one or group tuition provides academic support and prevent adolescents from being disengaged from school, education and learning environment.

Findings from this study indicated that stigmatization could have implications for the reintegration of adolescents in the community. This is consistent with a study with persons with mental disorders which indicated that stigmatization may sometimes be more socially hindering than the condition itself, leading to low self-esteem, social isolation and non-compliance with medication (Gerlach & Budde-Lund, 2004). Other prior studies have documented the experience of social isolation resulting from stigma, depletion of social networks, and limited opportunities and resources for socializing among people with mental disorder (Jones & Lewis, 2013; Kafai, 2013). Stigma and social isolation might be common to all persons with disabilities. However, the impact is far more profound and far-reaching on the identity, social interaction, and community integration of people with psychiatric disabilities (Beresford & Wallcraft, 1997). The importance of social support was highlighted in a study, which argued that social network and less social support were
associated with more frequent hospital admissions (Albert et. al, 1998). Social networks can have an impact on service use by providing information, mobilizing resources, avoiding stressors, facilitating access to services, avoiding social isolation, helping to plan hospital discharge and community care. The linkage of patients with their peers in the community is a normalizing intervention that helps ease patients’ transition from a highly structured ward milieu, which is often their only social support (Bjorklund, 2000).

5.3 Health system challenges towards reintegration

Findings from this study bring out an important issue on the stigma meted out by the community and colleague health professionals to mental health professionals. This stigma in most cases compel mental health professionals to be socially distant from persons with mental health problems. Lauber et al., (2004), found that psychiatrists compared with the general population were more willing to accept mental health facilities in the community, but were as socially distant to mentally ill people as the general population. (Lauber et al, 2004).

5.4 Community and environmental influences on reintegration

This study also revealed that hostile and unwelcoming environment could impose significant challenges to adolescents seeking to reintegrate into the community after mental health condition. The attitude of the people within the immediate surroundings of persons with mental illness could determine how fast a person could recover from disability. Mentally ill adolescents tend to develop low self-esteem due to societal attitude towards them and in some cases become offensive towards family and the community. Some of
these attitudes may be borne out of ignorance about the condition of persons with mental disorder. Wolfe et al (1996) revealed that people who have no knowledge of the mental illness of adolescents tend to shun their company. The process of reintegration could be extremely difficult to implement when the community exhibits negative attitudes based on the misconceptions about the causes of mental illness. A study in Nigeria revealed that despite people’s knowledge of the genetic and psychological causes of mental illness, they still associated mental illness as a punishment from the lesser gods or divine punishment or being caused by witches (Ukpong, 2010).
CHAPTER SIX
SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.0 Introduction
This study was to determine the challenges of reintegrating the adolescent with mental
disorders and the specific aims of identifying challenges faced by patents and their care

givers, the health system and the community.

A qualitative approach of research and a case study design was used to arrive at the current
findings.

This chapter enumerates the conclusions and the recommendations derived from the
findings of the study.

6.1 Conclusion
This study highlights the need for commitment of mental health professionals, the family
members of the adolescent patients and the community with the view of breaking the myths,
traditional knowledge and practices related to mental health illness for a more
encompassing and holistic realistic approaches. This study also contributes a distinct
perspective to the field of adolescent mental health care by offering insights into the
importance of community-based care supports and facility-to-workplace/school transitions
specifically for adolescents with mental health disorders. Finally, this study highlights
important themes of stigmatization towards patients, caregivers and mental health
professionals, social isolation, school and workplace reintegration strategies and community
support.
6.2 Recommendations

1. Psychosocial rehabilitation of the adolescent with mental illness ie. re-establishing community functioning and the well-being for a person who has mental illness. It’s important for reintegration to take place since an adolescent recovering from mental illness may have feelings of loss of control over their life, and loss of their identity and self-worth.

2. Helping adolescents managing and/or recovering from mental illness get good education and building skills to get income-producing work is a very important part of reintegration into society.

3. It is important that adolescents recovering from mental illness are given accurate and evidenced-based information regarding their illness.

4. Family and caretakers of adolescents with mental illness are important to reintegration of the patient back into society. Hence, family and caretakers also need education, guidance, and support on how to help the person reintegrate back into society.

5. The government and the mental health authority must seek to enforce the new mental health law especially the aspect of community care of the mentally ill adolescents inclusive. There should also be a continuous dialogue needed between those engaged in shaping policy and developing reforms and those involved in providing services on the ground.

6. Enough mental health cadres should be trained to augment the work of the already existing ones to help with the effective care of the mentally ill in the community.
7. Effective discharge planning and implementation should be practiced in collaboration with the community psychiatric nurses and social workers.
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APPENDIX A

Data collection instrument for clients

Demographic Data

Questionnaire Code: 001 Number of Patients: ....

Date of the Interview: ..........................................

1. Age: [] 1. < 20 years 2. 21-34 3. >35 years

2. Sex: [] 1. Male 2. Female


5. Religion [ ]


6. Educational Level: []


7. Ethnicity: []

   1. Akan 2. Ewe 3. Others (Specify) .........................

8. Has your place of residence changed due to the condition you are suffering from? [ ]

   1. Yes 2. No
History of disease condition

10. What do you think is the cause of mental disorders? [ ]
   1. Spiritual/Curse     2. Biological     3. Don’t Know

11. Where were you diagnosed of this mental disorder? [ ]
   1. Health Facility     2. Faith based Healing Centre     3. Self/Home management

12. How long have you been afflicted with this disease condition? [ ]
   1. < 1 year     2. 1-4 year     3. 5-9 years     4. 10-14 years     5. ≥15 years

13. Where was your first source of help/treatment for this condition? [ ]

14. What type of treatment do you prefer? [ ]
   1. Biomedical     2. Faith-based (Spiritual)     3. Others (Specify) …………
APPENDIX B

INTERVIEW GUIDE

Patient experiences towards reintegration

1. Have you lost your self-esteem or sense of identity in the community…………………

2. How do you relate to the other members of the community?……………………………

3. Will you like to talk to talk someone who knows much about your condition?

…………………………………………………………………………………………

4. Will you like to go to a different environment after you have being discharged from the hospital? …………………………………………………………………………………

5. Will you like to learn a trade or go back to your former employment to enable you earn some income? …………………………………………………………………………

6. If you will like to go back to school which level of the educational system will you prefer to begin from? ………………………………………………………………………

7. What do you know about your illness? …………………………………………………

8. What are some of the causes that you are aware of? …………………………………

9. Do you know some of the symptoms of your illness?……………………………………

10. What medications do you take and are you able to afford the treatment……………

11. How much support do you get from your family?……………………………………

12. Did your family members visit you when you were on admission at the hospital?…………………………………………………………………………………..

13. Do you have people staring at you or making negative comments about you?

14. Are you able to form long lasting relationship?………………………………………

University of Ghana  http://ugspace.ug.edu.gh
Experiences at the health Facilities

1. Are you treated with respect by hospital staff?

2. Has your diagnosis being made public to third parties without your knowledge?

3. Have health professionals tagged you with derogatory names during your stay in the hospital?

4. Does the hospital involve you in any activities such as gardening and other activities?

5. Are you treated differently from other patients without mental illness?

6. Do other patients treat you with respect when you interact with them?

Experiences with Community and Employers

1. Are you able to socialize with members of the community?

2. Do community members relate well with you?

3. Do the community members see you and call you other names other than your real name?

4. Are you able to go to the mosque or church without feeling embarrassed or anxious?

5. Have you been accepted back at work?

6. What’s the relationship between you and your employer and other employees?

7. Will you prefer to go back to work or stay at home and not do any work?
APPENDIX C

Data collection instrument for caregivers

My name is Sahl Mohammed Zabado, a postgraduate student with the Department of Health Policy Planning and Management of the School of Public Health, University of Ghana.

I am conducting a study to determine the Challenges of reintegrating the adolescent mentally ill in Madina.

Whatever information you provide in this study will be held in confidence and used only for this study.

Experiences of caregivers

1. Are you harassed by your friends because you have a sick relative?

2. Do you have your friends and other extended family members still visiting you at home?

3. Are you mocked at when you go to town or public events?

4. Have you lost a lot of resources financially because your relative is mentally ill?

5. Have you in any way been blamed for the predicament of your mentally ill relative?

6. Will you prefer patient stays with you at home or stays in the psychiatric hospital?
APPENDIX D

Data collection instrument for Health Professionals

My name is Sahl Mohammed Zabado, a postgraduate student with the Department of Health Policy Planning and Management of the School of Public Health, University of Ghana.

I am conducting a study to determine the Challenges of reintegrating the adolescent mentally ill in Madina.

Whatever information you provide in this study will be held in confidence and used only for this study.

Questions for health Workers (Psychiatrist and Nurses)

1. What’s your opinion about the stay of discharged mentally ill adolescents in the community

2. Are you in any way stigmatized for caring for the mentally ill

3. Do you think mentally ill patients should always be treated in the community

4. Will you prefer to nurse other patients other than mentally ill patients

5. What do think is the best form of treatment for the mentally ill

6. Will you recommend mentally ill patients are received back into school and work after leaving the psychiatric hospitals
APPENDIX E

Data collection instrument for community members

My name is Sahl Mohammed Zabado, a postgraduate student with the Department of Health Policy Planning and Management of the School of Public Health, University of Ghana.

I am conducting a study to determine the Challenges of reintegrating the adolescent mentally ill in Madina.

Whatever information you provide in this study will be held in confidence and used only for this study.

Questions for Community Members

1. What do you know about mental illness?

2. Will you like to live next door to a person with a history of mental illness?

3. Will you like to or allow any of your family members to marry a person with mental illness?

4. What do you think should be done to adolescents with mental illness who are very aggressive and have uncontrolled behaviours?

5. What’s your opinion about government building mental hospitals in the communities?

6. What’s your opinion about the community treatment of persons with mental illness?
APPENDIX F

CONSENT FORM

Project Title: Challenges of Reintegrating Adolescents with Mental Disorders into the Madina Municipality

Institutional Affiliation:

School of Public Health,
Health Policy Planning & Management Dept.
College of Health Sciences
University of Ghana
Legon

Background

Personal Introduction:

The Principal Investigator is Sahl Mohammed Zabado currently a master’s student of the School of Public Health, Legon and conducting a study on the Challenges of Reintegrating Adolescents with Mental Disorders into the Madina Municipality

This study is for academic purposes and a requirement for the award of Master of Science Degree in Applied Health Social science Degree and supervised by Dr. Abdallah Ibrahim of the Health Policy Planning and Management, School of Public Health, University of Ghana, Legon.
Procedure:

An interview will be conducted using questionnaires adapted purposely for this study.

Risks and Benefits

There is no foreseeable harm that may arise from participating in this research while benefits that may arise include a greater contribution to the development of mental health policy and acquisition of knowledge.

Right to refuse:

Although there are no known risks associated with the research protocols, if you feel uncomfortable you have the liberty to opt out. You are also at liberty to withdraw from participating if you desire to do so.

Anonymity and confidentiality:

You are assured that the information collected will be handled with the strictest confidentiality, will not be shared with third parties not directly involved in the research and thus will be used purely for academic purposes.

Before taking consent:

Do you have any questions that you wish to ask? If yes, questions to be noted.

If you have any questions you wish to ask later, or anything you wish to seek clarification on regarding the research, please do not hesitate to contact the Principal Investigator (Sahl Mohammed Zabado) on:

Telephone number: 020 2011430

Email:sahlmin27@gmail.com
Or the following officials

Hannah Frimpong
GHS-ERC Administrator
Office: 233 302 681109
Mobile: 233 (0)243235225 or 0507041223
Email

Nana Abena Kwaa
Assistant GHS-ERC Administrator
Mobile: 0244712919
Email: nanatuesdaykad@yahoo.com
PARTICIPANT

I .............................................................. a parent / guardian of Master/ Miss .............................................................. having been adequately informed about the purpose, procedures, potential risks and benefits of this study. I have had the opportunity to ask questions and any question I have asked have been answered to my satisfaction. I know that I can refuse to participate in this study without any loss or benefit to which I would have otherwise been entitled. Having gone through the consent form thoroughly I agree to enroll / my child in this study.

Name of participant: .................................................................................................................................

Signature or Right thumb print: .................................................................

Date: .................................................................

Interviewer’s Statement:

I have explained the procedure to be followed in this study to the client / client’s parent or guardian, in the language that he/she understands best and he/she has agreed to participate in the study.

Signature of interviewer ............................................................................................................................... 

Date.........................................................................................................................................................

Thank You.