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THE ROLE OF SELF-HELP GROUPS IN THE RECOVERY AND SOCIAL INCLUSION OF PERSONS WITH NEUROPSYCHIATRIC DISORDERS IN GREATER ACCRA, GHANA.

BY

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DECLARATION

I, Alexander Amponsah, hereby declare that this thesis is my own research work conducted under the joint supervision of Dr. Kwabena Frimpong-Manso and Kingsley Saa-Touh Mort. All authors whose works I cited have been duly acknowledged. This thesis has neither in whole nor in part been published or submitted for any other degree elsewhere.

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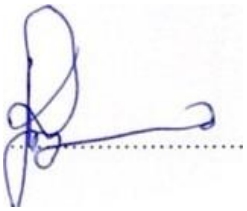
Signature  Date: 28/07/2021

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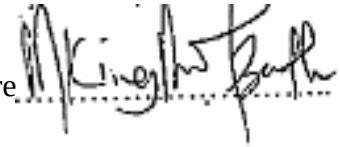
Signature  Date: 25/07/2021

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ABSTRACT

The contemporary mental health practice emphasizes the community-based approach which emphasizes Informal services, such as those provided by self-help groups (SHGs). Despite the greater need and prospects of SHGs, the mental health system in Ghana least recognizes and support them to serve as a complement to professional services. Moreover, there are very few research on SHGs in Ghana. Guided by the empowerment theory, I conducted this study to examine the contributions and effectiveness of SHGs in facilitating recovery and social inclusion of persons with neuropsychiatric disorders in Greater Accra, Ghana. The concurrent-embedded mixed methods was used to guide this study. Specifically, the static-group comparison design was used for the quantitative study, and descriptive phenomenology was used for the qualitative study. A total of 162 persons participated in the quantitative study, comprising 77 SHG members and 85 non-SHG members. The qualitative participants were 13. It was found that SHGs facilitate the recovery and social inclusion of members through the provision of psychosocial support. This plays out in three pathways namely social support, promotes social integration, and promotes proper management of the disorder. SHG members recover better than non-SHG members [$t(160) = 3.02$, $p < .005$]. More so, SHG members are included in society better than non-SHG members [$t(158) = 3.46$, $p < .001$]. The magnitude of the differences in recovery and social inclusion for the two groups was moderate ($d = .5$). SHGs make moderate positive impact on the recovery and social inclusion of members with neuropsychiatric disorders. Stakeholders in mental health are encouraged to establish and support SHGs to promote recovery and social inclusion of persons with neuropsychiatric disorders in Ghana, especially in urban places.

DEDICATION

I dedicate this thesis to my father, Robert Asiedu and mother, Elizabeth Quaicoe for their selfless support which has brought me this far.

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ACRONYMS

DACF: District Assembly Common Fund

MESOG: Mental Health Society of Ghana

MHA: Mental Health Authority

MOH: Ministry of Health

PWDs: Persons with Disabilities

SA: Social Acceptance

SHGs: Self-help groups

SI: Social Isolation

SIS: Social Inclusion Scale

SR: Social Relations

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Mental disorders are health problems that affect cognition, behavior or perception, and disrupt social, occupational, and other areas of functioning of people (Colman, 2015; Molineux, 2017). Example of mental disorders is Schizophrenia (Cohen et al., 2012; Kessler et al., 2008; Wittchen et al., 2011). Neurological disorders refer to health problems that are linked to the central and peripheral nervous system including the brain, spinal cord, and peripheral nerves (Wittchen et al., 2011). Example is epilepsy (Gourie-Devi, Gururaj, Satishchandra, & Subbakrishna, 2004; Wittchen et al., 2011). Both mental and neurological disorders are referred to as neuropsychiatric disorders (Wittchen et al., 2011). Neuropsychiatric disorders are common health problems present in every society. The global lifetime prevalence of mental disorders ranges from 12.0% in Nigeria to 47.4% in the United States (Kessler et al., 2007). The survey also revealed that 17% - 69% of the global population stand the risk of experiencing mental disorders before death (Kessler et al., 2007). The prevalence of epilepsy is estimated to range from 4 to 10 per 1000 people across the globe (Engel, Pedley, & Aicardi, 2008).

Persons with neuropsychiatric disorders face social and personal problems which make them vulnerable in living a satisfying life (WHO, 2013). In the light of this, recovery and social inclusion are being promoted as primary mental health outcomes across the globe (WHO, 2013). Recovery in mental health does not imply the absence of psychiatric disability, but rather a state of wellbeing marked by the ability to live a full, hopeful, and rewarding life despite sickness (Leamy et al., 2011; Slade, Amering, & Oades, 2008). Recovery is a process characterized by improvement in wellbeing such that development in any aspect of one's life

is valued (Sklar, et al., 2013). The exact domain for defining recovery is a subject of debate, albeit it is multidimensional. In this study, five domains were used to define recovery namely personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and no domination by symptoms (Corrigan, Salzer, Ralph, Sangster, & Keck, 2004). The concept of social inclusion emphasizes the importance of social relationship and participation in social activities in the overall wellbeing of persons with mental health problems (Onken et al., 2007). The definition of the term is a subject of debate as scholars conceptualize it in multidimensional ways (Chan et al., 2013). In this study, I define the concept of social inclusion from three main dimensions namely social relations, social acceptance, and no or low incidence of social isolation (Secker, Hacking, Kent, Shenton, & Spandler, 2009).

Some macro level interventions have been developed to promote the recovery and social inclusion of persons with neuropsychiatric disorders. At the global level, WHO developed the Mental Health Action Plan 2013-2020. This policy provides roadmap for individual countries on ways to strengthen leadership and governance for mental health, promote community-based mental healthcare, prevent mental disorders, and promote research and knowledge about mental health. It is worthy of note that the macro level interventions are primarily geared toward improving mental health outcomes through services delivered by mental health professionals. They, however, emphasize less on informal care. Meanwhile, there is evidence that services provided by actors in the informal support system are key complement to professional services in facilitating mental health outcomes (Nguyen, Holton, Tran, & Fisher, 2019). Self-help groups (SHGs) are identified as a key informal support system in mental health (Markowitz, 2015). Several studies (e.g Bennet et al., 2018; Burti et al., 2005; Hedlund et al., 2019; Pistrang & Barker, 2008) provide evidence that participation in SHGs is associated with beneficial impacts on mental health outcome. For instance, a recent study on the usefulness of SHGs in Norway revealed that participation in SHGs by persons with chronic

diseases including chronic mental illness resulted in the promotion of self-care (Hedlund et al., 2019).

In Africa, the prevalence of neuropsychiatric disorders is reported to be higher than the global estimate. For instance, 20 – 49 out of every 1000 people in Africa live with epilepsy (Engel et al., 2008). Conversely, resources and policies needed to promote the wellbeing of persons with neuropsychiatric disorders are less developed in the region. For instance, approximately 42% of countries in Africa have mental health policy compared to 60% and 73% countries in the world and Europe, respectively. Evidence suggests that SHGs for persons with neuropsychiatric disorders in Africa make a positive impact on the overall wellbeing of participating group members. For instance, a transnational study in Africa revealed that participation in SHGs promotes advocacy, access to health care, and provide key support for group members (Kleintjes, Lund, & Swartz, 2012).

In Ghana, 18.7% of the population is estimated to have mental disorders, with 7.0% showing symptoms of severe mental disorders (Sipsma et al, 2013). In addition, the prevalence of epilepsy is estimated to be 10.1/1000 people (Ayuurebobi et al., 2015). Some key interventions undertaken by the government to promote the recovery and social inclusion of persons with neuropsychiatric disorders in Ghana include the Kintampo Project 2007 – 2017 (Ayuurebobi et al., 2015). This project has trained mental health professionals, especially, community mental health officers to promote and deliver community-based mental healthcare. The Mental Health Act, 2012 (Act 846) is the legislation which outlines strategies to protect and promote human right of persons with neuropsychiatric disorders in Ghana. The Act also established the mental health authority and creates the mental health fund. The Mental Health Strategy 2014-2018 is another policy which sought to adapt and implement the targets set in the Mental Health Action Plan 2013-2020. Other policies include the Communication Strategy on Stigma Reduction and Discrimination Against Persons with neuropsychiatric disorders,

which seeks to address mental health stigma (MHA, 2018). The presence of SHGs for persons with neuropsychiatric disorders in Ghana is well documented (Cohen, et al. 2012; Sakyi, 2015). The available reports denote that SHGs aid members to get financial support, promotes social inclusion, and enhances treatment and clinical outcome of members (Cohen et al., 2012; Sakyi, 2015). In view of this, this study sought to examine the contributions and effectiveness of SHGs in promoting recovery and social inclusion of members.

1.3 Overview of Self-help groups for persons with neuropsychiatric disorders in Ghana

SHGs operate on mutual aid principles and promote a bottom-up system of service delivery which has the potential to empower members. SHGs can focus on one or more of the following objectives: the provision of mutual support, social activism to change social policies, promote self-empowerment of menbers, public sensitization on mental health, and linking members to economic resources outside the group (Hedlund et al., 2019; WHO, 2013). Self-help groups in Ghana has unique features and this corroborate the fact that variations in SHGs is common across groups. I describe SHGs in Ghana in terms of history, membership, organizational structure, and functions.

1.3.1 Historical antecedents of self-help groups for persons with neuropsychiatric disorders in Ghana

In their pioneering study of SHGs in Ghana, Cohen and his colleagues (2012), recounted that SHGs in Ghana was borne out of wishes expressed by persons with neuropsychiatric disorders and their caregivers to BasicNeeds-Ghana, a mental health NGO to establish SHGs. The service users pointed out that a group that brings them together could offer them opportunities to discuss issues of common interest and promote mutual support. The need expressed was considered by BasicNeeds-Ghana, and with funding from Comic Relief and UKAID, a five-year project of establishing SHG was undertaken in the operational areas of the NGO. It is reported that the initial groups were established between 2004 and 2009 (P. B. Yaro, Personal

communication, November 26, 2019). In the beginning, the groups served members from different communities, a structure which proved challenging to most members in attending meetings. In view of this, from 2007 the SHGs were reorganized to be community specific such that each community in the operational areas of BasicNeeds-Ghana would have a SHG for the service users.

The number of SHGs increased over time. For instance, in 2012, 239 SHGs with membership of 10,730 existed across the operational areas of BasicNeeds-Ghana, and this number increased to 569 with membership of 33,077 in 2019 (BasicNeeds-Ghana, 2012). BasicNeeds-Ghana also facilitated the creation of a more robust organizational structure where service users are well mobilized to actively participate in mental health campaign, advocacy, and mutual support. This resulted in the formation of the Mental Health Society of Ghana (MEHSOG) in 2009 to serve as a resource center for service users and the highest decision-making body for SHGs (BasicNeeds-Ghana, 2013; Mental Health Society of Ghana, 2011; Registrar of Companies-Ghana, 2009). Currently, both MEHSOG and BasicNeeds-Ghana support the activities of SHGs through a bottom-up relationship.

1.3.2 Membership in self-help groups for persons with neuropsychiatric disorders in Ghana

Membership in SHGs is limited to persons living with neuropsychiatric disorders, and their caregivers or family members (BasicNeeds-Ghana, 2012; Cohen et al., 2012; Sakyi, 2015). Cohen et al. (2012) reported that diagnosis of participants in SHGs in the Northern part of Ghana comprised of epilepsy (55.5%); severe mental disorders such as schizophrenia, Unspecified Psychosis, Bipolar Disorder, and Depression with Psychotic Symptoms (28.7%); other neurological disorders including dementia, headache, and autism (11.1%); common mental disorders namely anxiety and depression (4.2%); and unknown diagnosis (0.4%). This implies that membership in SHGs in Ghana is open to persons or caregivers of persons with

different mental and neurological disorders. It is reported that approximately half of members of SHGs are caregivers or family members (Cohen et al., 2012).

1.3.3 Organizational structure of self-help groups for persons with neuropsychiatric disorders in Ghana

The structure of mental health SHG is a pyramid built on foundations of problem identification, problem solving, mutual support, flow of information and resources, and alliance to formal organizations, notably BasicNeeds-Ghana and MEHSOG. Each SHG is a community-based and is independent of others in different communities. The community-based SHGs is the most important unit of the structure as all the other units derive strength from it. The leadership structure of SHGs start from the base and enjoins all the groups at the national level.

At the community level, the leaders are appointed or elected by the members (Sakyi, 2015). The four leadership positions that are common to all SHGs are chairperson, organizer, secretary, and treasurer. However, some groups have assistant chairperson position in addition to the four mentioned (MEHSOG, 2011). Sakyi (2015) reports that these positions are open to only members in the SHGs, making it empowering to the members. Figure 2.1 provides a framework of the structure of SHGs in Ghana.

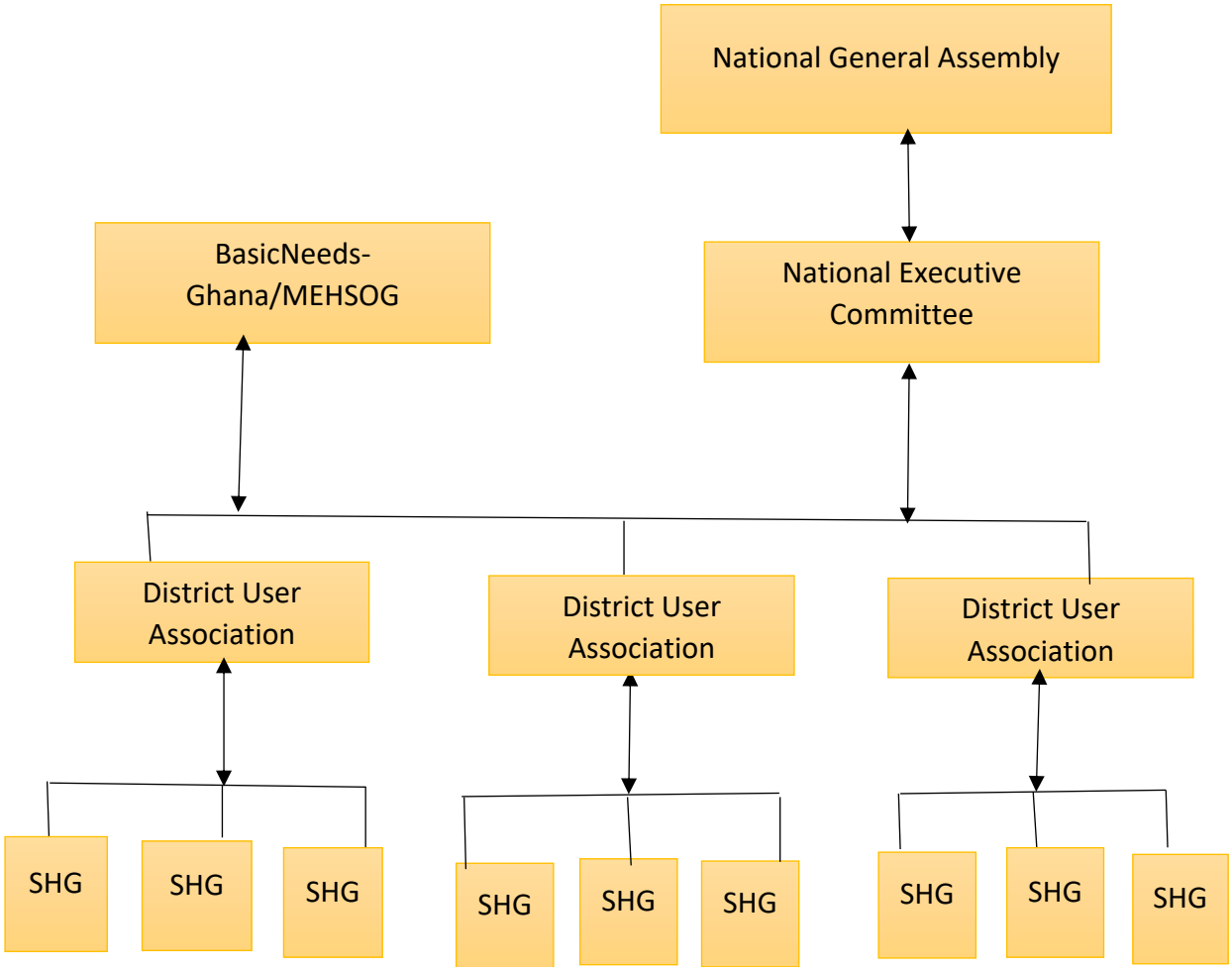

Figure 1.1: Structure of self-help group in Ghana

Adapted from MEHSOG (2011)

MEHSOG (2011) details the structure of SHGs as part of the service user society. The executives from the community SHGs come together to constitute the District User Association. Each District User Association appoints one person who serves as a volunteer to the district. The District User Association meet to discuss issues that are particularly related to the groups in the district, plan and organize programs for the groups, consolidate and resolve problems presented by leaders of the individual groups. Issues that require support from higher authorities are sorted and channeled to the befitting organization through the volunteer. This can be by directly contacting BasicNeeds-Ghana/MEHSOG or channeling it to the National Executive Committee.

In each region, one of the district volunteers is appointed to represent the region at the national level. These regional representatives constitute the National Executive Committee. This committee meets every six months, and some of the activities undertaken include reviewing progress in the SHGs, discussing current problems, and identifying key issues to be presented to the National General Assembly for resolution. The National General Assembly is the highest decision-making body of the user associations, and it is primarily composed of the Executive Secretary of MEHSOG and members of the National Executive Committee. This committee meets once in every two years to deliberate on reports from each region, resolve emerging problems and make key decisions that are of interest to each SHG established by BasicNeeds-Ghana (H. M. Kofie, personal communication, July 24, 2020).

The structure is a bottom-up one such that members in SHGs channel their unmet needs and unresolved problems to their volunteers through their group executives, and the volunteer might resort to MEHSOG, BasicNeeds-Ghana or the National Executive Committee through the regional representatives for support. Also, information and resources from MEHSOG and/or BasicNeeds-Ghana pass through the district volunteers, to the executives of the SHGs and to the members. Likewise, feedback from the National General Assembly or the National Executive Committee is passed over to SHG members through the regional representatives, the district volunteers, and finally the SHG executives.

1.4 Statement of the problem

The objective three of the WHO's Mental Health Action Plan 2013-2020 emphasizes the need to provide integrated mental health services in a community-based setting (WHO, 2013). The primary goal of the community-based mental healthcare is to make services accessible in communities in which service users live (MHA, 2018; Ministry of Health, 2013). This approach is touted as more effective in facilitating recovery and social inclusion for mental health service users (Ministry of Health, 2013). The WHO Pyramid Framework further

emphasizes that informal mental health services comprising self-care and informal community care are the most important and frequently needed services to advance the recovery and social inclusion of service users. SHGs are key support system that provide informal mental health services (Markowitz, 2015; MHA, 2018).

Despite the present focus on informal mental health services and the potential of SHGs, they are only marginally acknowledged and supported in Ghana as a critical addition to the formal mental health system. In addition, the traditional informal systems that provide care to persons with neuropsychiatric disorders in Ghana such as the extended family are weakening due to factors such as modernization, changes in legal frameworks, migration, and commercialization (Kpoor, 2015). For instance, some persons with neuropsychiatric disorders in Accra, Ghana are migrants from other parts of Ghana who live alone in a rented apartment or with only members of the nuclear family. Consequently, they do not get access to care from members in the extended family. The few members in the nuclear family may be constraint by time as they go out to work early and come back late. This situation makes it difficult for some persons with neuropsychiatric disorders to get the needed care to maximize their recovery and social inclusion. Also, given the urban context of Greater Accra Region, individualized lifestyle is dominant compared to rural settings. Neighbours hardly provide care to one another because there exist no or little ties among them. This is because most of the residents are migrants from other parts of the country who are there to explore economic opportunities. In view of this, SHGs play a critical role in bringing people of common needs together, inspire members to provide support to one another, and strengthen relationship with one another. For persons with neuropsychiatric disorders, SHG members could assist in the provision of care through peer support. Thus, SHGs could be a functional fit in this era in providing mutual support and care to persons with neuropsychiatric disorders, especially in urban places.

Also, given that professional mental health provision in Ghana is largely inadequate, and that mental health treatment gap in Ghana is 98 percent (Dixon, 2012; MHA, 2018), SHGs could contribute to addressing these challenges. Despite these perceived prospects, there is little empirical information on the roles of SHGs in the mental health system of Ghana. The few studies conducted in Ghana (Cohen et al., 2012; Sakyi, 2015) used only the qualitative approach and did not focus on the effectiveness of SHGs in promoting the recovery and social inclusion of participants. More so, studies (in contexts outside of Ghana) that have taken a quantitative measure of the extent to which SHGs promote recovery and social inclusion report mixed results (Markowitz, 2015; Pistrang et al., 2008).

Consequently, this study adopted the mixed methods approach to examine the contributions and effectiveness of SHGs in facilitating recovery and social inclusion of persons with neuropsychiatric disorders in Greater Accra, Ghana.

1.5 Research objectives

The study aimed at achieving the following objectives:

I. Explore the ways in which participation in SHGs facilitate recovery and social inclusion of persons with neuropsychiatric disorders.
II. Compare the level of recovery for persons with neuropsychiatric disorders who belong to SHGs and those who do not.
III. Compare the level of social inclusion for persons with neuropsychiatric disorders who belong to SHGs and those who do not.

1.6 Research questions

The current study intends to provide answers to three research questions:

I. In what ways do participation in SHGs facilitate the recovery and social inclusion of persons with neuropsychiatric disorders?
II. What similarity or difference exists between the level of recovery for persons with neuropsychiatric disorders who belong to SHGs and those who do not?
III. How similar or different is the level of social inclusion for persons with neuropsychiatric disorders who belong to SHGs and those who do not?

1.7 Hypothesis

In line with the tenets of the empowerment theory (as found in chapter two) used to guide this study and the available qualitative studies conducted in Ghana, four tentative statements that predict the effectiveness of SHGs on recovery and social inclusion are stated below.

Table 1.1

Statement of the null and alternative hypotheses

	Null hypotheses	**Alternative hypotheses**
1a	Persons with neuropsychiatric disorders who belong to SHGs are not likely to recover better than non-SHG members on the Short Version of the Recovery Assessment Scale.	Persons with neuropsychiatric disorders who belong to SHGs are likely to recover better than non-SHG members on the Short Version of the Recovery Assessment Scale.
1b	Persons with neuropsychiatric disorders who belong to SHGs are not likely to recover better than non-SHG members, on all the five subscales of recovery.	Persons with neuropsychiatric disorders who belong to SHGs are likely to recover better than non-SHG members on at least one of the five subscales of recovery.
2a	Persons with neuropsychiatric disorders who belong to SHGs are not likely included in society better than non-SHG members on the Social Inclusion Scale.	Persons with neuropsychiatric disorders who belong to SHGs are likely included in society better than non-SHG members on the Social Inclusion Scale.
2b	Persons with neuropsychiatric disorders who belong to SHGs are not likely included in society better than non-SHG members, on all the three subscales of social inclusion.	Persons with neuropsychiatric disorders who belong to SHGs are likely included in society better than non-SHG members, on at least one of the three subscales of social inclusion.

1.8 Variables

The hypotheses are grounded on four variables. The independent variables are two comprising participation in SHGs, and non-participation in SHGs. This translates into two groups of which one belongs to SHGs and the other does not. The dependent variables are two namely recovery and social inclusion. Thus, it is theoretically assumed that recovery and social inclusion are subject to the influence of participation and non-participation in SHGs.

1.9 Significance of the study

This study could make great contribution to research, practice, policy, and theory.

Contribution to research

The findings from this study will contribute greatly to knowledge about the impact of SHGs on the recovery and social inclusion of persons with neuropsychiatric disorders. This will increase the available empirical records about SHGs and hence contribute to literature in the field of mental health, a multidisciplinary field. This study will provide evidence-based recommendations for area of need for future research on SHGs, and this will provide great insight to researchers and other stakeholders.

Contribution to practice

This study provides knowledge for practitioners, including social workers, psychologist, psychiatrist, and service providers in mental health on the facilitating role of SHGs in recovery and social inclusion. This could influence practitioners to link clients to SHGs upon assessment of needs. Practitioners and mental health service users could also tap into some of the strengths of SHGs that will established by the study, to deal with human right issues and negative cultural attitudes toward persons with neuropsychiatric disorders. If found to be an effective approach to informal mental healthcare, it will unveil another area of practice where practitioners can pay attention to and promote its sustenance. For persons with

neuropsychiatric disorders, the outcome of this study could guide them in making informed decisions about the need to join SHGs. This is because this study will project in clear terms the link between recovery and social inclusion and participation in SHGs.

Contribution to policy

The report from this study could inform the government, through the MHA, MOH, and Ghana Health Service (GHS) about the ways in which SHGs are useful in promoting community-based mental health. This could inspire the government to incorporate SHGs into the broader structure of mental healthcare delivery system in Ghana and allocate resources to support their activities. Also, the research report could inform donors and mental health NGOs to promote the establishment and sustenance of SHGs and adopt it as an intervention in delivering mental healthcare.

Contribution to the utilization of the empowerment theory

This study will advance knowledge about the application of the empowerment theory in the field of mental health, and invariably increase understanding about how the theory can be adapted in social work research and practice. More so, this study will test the tenets of the theory as the theory is used in a deductive form.

1.10 Organization of the study

This thesis is divided into six chapters. The study's first chapter contains information on the study's background, an overview of SHGs in Ghana, a problem statement, research aims and questions, hypotheses, the study's importance, and definition of terminologies. The second chapter is devoted to a review of the empirical literature as well as the theoretical framework used. The third chapter discusses the study area, research design, population and sampling, data gathering methods, data collection tools, data analysis, ethical considerations, and study limitations. Chapter four focuses on the presentation of findings on the three objectives.

Chapter five is dedicated to the discussion of findings. Chapter six provides the summary of findings, recommendations, and conclusion.

1.11 Definition of terminologies

Recovery: A personal process and a way of life characterized by living a satisfying, hopeful and productive life even with the presence of psychiatric disabilities (Anthony, 1993).

Social inclusion: The extent to which an individual realizes his/her rights and can participate, by choice, in the ordinary activities of society (Mental Health Commission, 2009).

Self-help group: A peer support local organization run by persons with persons with neuropsychiatric disorders, and their family members or caregivers (Cohen et al., 2012).

Biomedical treatment: Medications and psychotherapy provided by mental health professionals in primary mental health hospitals.

psychosocial support: Care provided to SHG members to promote their psychological and social wellbeing.

Review: Regular appointment with a mental health professional at mental health facility.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section is dedicated to the review of existing literature. The review is organized into three major components which cumulate to provide empirical and theoretical information on the objectives of the current study. They comprise of the link between SHGs and recovery, the link between SHGs and social inclusion, theoretical perspective, and gaps in literature.

2.2 The link between self-help groups and recovery

The idea that recovery is a fully personal journey does not disregard the importance of external resources. Anthony (1993) used the term "recovery triggers" to emphasize the role of environmental conditions in recovery. SHGs, according to Anthony (1993), are natural resources that aid recuperation. SHGs, on the other hand, were discovered by Deegan (1988) as an optional resource that people with neuropsychiatric illnesses can use to help them recover. In both cases, SHGs are recognized as a notable resource that facilitates recovery.

Pistrang et al. (2008), systematically reviewed 12 studies to assess the effectiveness of SHGs in promoting the psychological and social wellbeing of persons with mental disorders. They observed that two studies (Bright, Baker, & Neimeyer, 1999; Marmar, Horowitz, Weiss, Wilner, & Kaltreider, 1988) that compared service users receiving SHG intervention with those receiving expensive professional services reported equivalent positive outcomes. This means that SHGs, though less costly, was effective in facilitating psychological and social wellbeing. Pistrang et al. (2008) however, observed that five out of the twelve studies (Tudiver, Hilditch, Permaul, & McKendree, 1992; Caserta & Lund, 1993; Videka-Sherman & Lieberman, 1995; Powell, Hill, Warner, & Yeaton, 2000; Cheung & Sun 2000) reported no significant improvement in the outcomes measures for those who participated in SHGs and

those who did not. The authors concluded that SHGs can have only positive or no significant impact on members.

Markowitz (2015) conducted a quantitative study with longitudinal design to examine the link between participation in SHGs, empowerment, and recovery for persons with mental disorders in the United States of America. The study revealed that active involvement in SHGs significantly promoted self-esteem among group members but resulted in increased perceived stigma for group members. Also, active involvement in SHGs did not make any significant positive impact on quality of life and symptom reduction. The authors declared that although beliefs about stigma increased with increased involvement, the study could not assess its impact on recovery and empowerment. They however observed some slight improvement in recovery and empowerment for SHG members. Consequently, they concluded that SHGs make modest positive impact on recovery and empowerment. Sakyi (2015) reported in his qualitative study that members of SHGs learn about stigma and how they are used against them, a knowledge which increases their awareness. This could be what Markowitz (2015) observed as increased belief about expected stigma. Sakyi (2015) also revealed that SHGs focus on equipping members with knowledge and skills in coping with stigma.

Lloyd-Evans and Colleagues (2014) conducted a systematic review and meta-analysis on studies that utilized control trials to assess the effectiveness of SHGs in promoting mental health outcomes for persons with severe mental disorders. The review was done with 18 studies with a sample size of 5597. Ten mental health outcomes were assessed, but only four relate to personal recovery, namely, quality of life, recovery, hope, and empowerment. The authors reported evidence of positive impacts of SHGs on hope, recovery, and empowerment, but this finding was not consistent across all the studies sampled, except for recovery. Thus, all four studies on recovery reported significant improvements but with only small effect sizes. Four of the five studies on empowerment found no significant difference between SHG and non-

SHG members. One of the five studies on hope found no significant difference between SHG and non-SHG members. And five of the six studies on quality of life found no significant difference between SHG and non-SHG members. No study, however, observed reduction in any of the outcome measures after the interventions. Lloyd-Evans et al. (2014) concluded that there is just a little evidence of positive effect of SHGs for persons with severe mental disorders, and that SHGs should not be recommended or made a mandatory component of mental healthcare in contexts where high evidence of effectiveness has not been revealed by research.

Fukui, Davidson, Holter, and Rapp (2010) studied the effect of participating in pathway to recovery (PTR) peer-led groups on recovery. Forty-seven persons with severe and chronic mental disorders were studied using the single group pretest-posttest design. In PTR peer-led groups, the facilitator and participants use the guidelines in the PTR handbook to guide group discussions, identify individual goals and assign tasks to members to complete. The constructs that were used to represent recovery are self-esteem, self-efficacy, social support, spiritual well-being, and psychiatric symptoms. The study reported a significant improvement in all the measures of recovery. The authors concluded that participation in a PTR peer-led groups is a key facilitator of recovery for persons with severe and chronic mental disorders. This study has a lot of strengths including the assessment of recovery from multiple domains. It must be noted however that the use of PTR peer-led group makes the group composition and the group culture different from the SHGs that the current study is investigating.

In their quest to identify the effectiveness of combined services delivered by mental health agency (self-help group) and community mental health agency (primary mental healthcare centre) in promoting recovery, Segal, Silverman, and Temkin (2010), used the randomized control trial to study 505 persons with serious mental disorders. Two groups were compared, where one group received services from both agencies and the other received

services from only the community mental health agency. The domains of recovery assessed were personal empowerment, self-efficacy, social integration, hope, and psychological functioning. It was found that participants who received services from both agencies significantly recovered better than those who received services from the community mental health agency. Independently, SHG members were better recovered on measures of personal empowerment, self-efficacy, and social integration. The finding points to the fact that participation in SHG was the most obvious independent variable that caused the significant improvement in the group that received services from both agencies. The research design gives strength to the findings compared with studies that focused on only one group (example Fukui et al., 2010).

Mak et al. (2021) conducted a longitudinal study in Hong Kong to assess the impact of recovery dimensions of peer support workers on the recovery outcomes of service users. The study revealed that the levels of hope and self-esteem of peer support workers were significantly associated with the improved levels of hope and empowerment among service users. This finding led to the conclusion that the recovery attributes of peer support workers are beneficial to service users as they use them as role models. Similarly, in their meta-analysis of studies on peer support delivered on one-on-one basis, White et al. (2020) observed that the intervention had a positive impact on the psychosocial wellbeing of mental health service users. Specifically, the intervention positively impacted on recovery and empowerment outcomes of service users. The authors however observed that the intervention had no impact on the reduction of psychiatric symptoms.

2.3 The link between self-help groups and social inclusion

In his qualitative study of the role of SHGs in the rehabilitation of persons with mental disorders in Ga-Mashie, Ghana, Sakyi (2015) outlined several benefits of SHGs in relation to social inclusion. He found that SHGs provide access to material and financial resources. These

resources come in the form of interest-free loans given to members by NGOs such as BasicNeeds-Ghana, and provision of free medication. In addition, he found that SHGs make members become active as they attend meetings, engage in discussions, and participate in activities such as educational outreach programmes organized by the group. One notable evidence of social inclusion reported was that SHGs have members, such as family members and caregivers who do not live with neuropsychiatric disorders. As a result, persons with mental disorders get the opportunity to interact with group members who are not different from persons in society. This finding confirms studies by Mead et al. (2001); Yanos, Primavera, and Knight (2001), who found that persons with mental disorders who engaged in SHGs were able to create new relationships, renew their personal identity, and had better social functioning than those who were not in SHGs. In view of this, Kurtz (1990) explained that persons with mental disorders who engage in activities of SHGs become exposed to the outside world, which provide them with novel ways of perceiving issues, and get role models.

Cohen et al. (2012), used qualitative approach to study the impact of SHGs in the lives of participants in the Northern part of Ghana. The study revealed different ways that SHG was useful in promoting social inclusion of members. Members in SHGs received mutual support. For instance, it was reported that members fetched water and cooked for those who had given birth and others provided financial support to peers who were in need. Moreover, through educational programmes organized by SHGs, members reported increased acceptance by family and community members. Moreover, members had access to interest-free loans which was used to engage in economic activities such as petty trading, and farming. These loans were provided by NGOs, especially, by BasicNeeds-Ghana.

The findings from Cohen et al. (2012) are consistent with studies conducted in other countries. In their longitudinal study, Ochocka et al. (2006) found that SHG members who were active reported having more friends and social support, both within and outside the group.

They also reported that persons with mental disorders in peer support groups had reduced stigma and were more likely to engage in economic activities and educational programs.

A quantitative study conducted by Nelson, Ochocka, Janzen, and Trainor (2006) confirmed that active peer support group members had social support, and improved involvement in economic and educational activities than inactive members. The study however found no significant improvement in community integration for active and non-active members. It was also found that both active and non-active members had reduced social integration after 18-month follow-up.

2.4 Theoretical perspective.

This section presents the theoretical perspective adopted for the current study. It must be established that many theories have been linked to the essence and functions of consumer-led organizations for persons with neuropsychiatric disorders including empowerment theory, social support, experiential knowledge, helper-therapy principle, social learning theory, and social comparison theory (Solomon, 2004). However, this study adopted only one of the theories to provide explanations and make predictions about the contributions and effectiveness of SHGs in facilitating recovery and social inclusion of persons with neuropsychiatric disorders.

2.4.1 Tenets of the empowerment theory

The empowerment theory is proposed to guide the conduct of this study. The empowerment theory was first proposed by Julian Rappaport, an American social Psychologist in 1981. Other scholars have expanded the theory including Marc Zimmerman, and Andrew Peterson. The theory is used at one or more of the levels of analysis, namely psychological, organizational, and community, in fields such as social work, psychology, political science, disability studies, among others.

Empowerment is a participatory process by which individuals, organizations, and communities gain power to influence issues that interest them (Rappaport, 1987). Thus empowerment "conveys both a psychological sense of personal control or influence and a concern with actual social influence, political power, and legal rights often through mediating structures such as schools, neighbourhoods, churches, and other voluntary organizations" (Rappaport, 1987, p. 121). The key tenet of empowerment theory is that opportunity to participate in activities, decision making and share resources between and among people influence the individuals to become empowered (example experience personal well-being, social functioning and inclusiveness in society) (Rappaport, 1987; Zimmerman, & Warschausky,1998; Peterson & Zimmerman, 2004).

Theoretically, empowerment connotes both a process and an outcome (Rappaport, 1987; Zimmerman, 1995). Thus actions, activities and social structures could be empowering, and the results of these processes could lead to a state of being empowered (Zimmerman, & Warschausky,1998). Empowerment process are the mechanisms through which individuals, groups or communities take initiatives to gain control, realize the resources in their environment and possess the skills to get the needed resources (Zimmerman, 2000; Zimmerman, & Warschausky,1998). The focus of empowerment process is to provide an opportunity for individuals, organizations, and communities to gain autonomy, access resources, and become critically aware of their socio-political contexts (Zimmerman, 1995). Examples of empowerment process may include opportunity to learn and practice (new) skills, create new social support network, and to master leadership skills (Zimmerman, 1995). The opportunity needed for empowerment process to thrive may be provided by structures such as schools, neighborhoods, churches, and user-led groups (Rappaport, 1987). The primary goal of empowering process is to produce an empowerment outcome and related benefits such as good health (Zimmerman, 1995). Both empowerment processes and outcomes are multidimensional

and context-sensitive because no single measure can exhaustively capture its meaning for all people in all contexts (Rappaport, 1984; Zimmerman, 1995, Zimmerman, 2012).

Empowerment theory has three levels of analysis namely psychological/individual, organizational, and community (Rappaport, 1987; Zimmerman, 2000). The psychological level of analysis involves beliefs about personal competence, positive self-concept, ability to take control over one's own life and being aware of the resources available in the socio-political environment that can be utilized to advance one's well-being (Zimmerman, 2000). Zimmerman (1995) categorized empowerment outcomes at the psychological level into three components: intrapersonal, interactional, and behavioral. The intrapersonal component refers to perceptions that an individual hold about him/herself and these include self-efficacy, perceived competence, and the inspiration to act to influence different domains of life such as family, work, and community. The interactional component refers to understanding that individuals have about their environment, including socio-political issues, that enable them to relate with others, and access needed resources. The skills and understanding is described as critical awareness and involves knowing the resources available in one's environment, possessing the knowledge and skills in acquiring them, and being able to manage them efficiently once they are acquired (Kieffer, 1984; Zimmerman, 1995). The behavioural component "refers to actions taken to directly influence outcomes" (Zimmerman, 1995, p. 590), including coping behaviours, job seeking behaviors, and participating in group and community activities.

The individual level empowerment outcomes are facilitated by empowerment process which involves a personal participation in an activity with others and taking actions to influence personal and external structures to advance a personal or shared interest (Zimmerman, 2000; Zimmerman & Rappaport, 1988; Zimmerman, & Warschausky,1998). For example, one way of developing on an individual's analytical skills is through participation in group and/or community activities (Zimmerman & Rappaport, 1988). This is true because such participation

helps to decrease the sense of powerlessness, and isolation that may accompany disabilities (Berger & Neuhaus, 1977).

The organizational level of analysis focuses on the structure of organizations (such as self-help groups, churches, schools etc.) that promote individual participation in activities and the ability of the organization to meet its goals. A distinction is therefore made between empowering and empowered organizations (Zimmerman, 2000). Empowering organizations provide favourable contexts for members to obtain psychological empowerment outcomes such as interactional skills, self-confidence, and motivation to take personal responsibilities over their own issues. Empowering organizations therefore provide contexts within which individuals can share information and experiences and build a sense of belongingness and interdependence (Zimmerman, 1987). Organizations that share responsibilities, provide context for peer support, and engage members in activities are expected to be more empowering than hierarchical organizations (Maton & Rappaport, 1984; Zimmerman, 1995). Thus, empowering organizations focus primarily on aiding members to become empowered (Peterson & Zimmerman, 2004). Empowered organizations focus on influencing the macro system in which they live (Peterson & Zimmerman, 2004). Such organizations primarily seek to cause social change in areas such as laws, cultural values, and perceptions about a group. In the context of this study, the organization in question is expected to be empowering such that it can facilitate individual level empowerment outcomes.

The community level of analysis refers to individuals working in unity to improve their lives and the interconnectedness among community organizations and agencies that work to promote the wellbeing of community members (Zimmerman (1995). Communities that provide equal access to resources, allow for the expression of diverse opinions, and build structures or institutions that are accessible to all members are more able to promote empowerment outcomes in members (Zimmerman and Rappaport, 1988). Thus, in communities where

members are provided opportunities to participate in activities, they produce more empowered members. Key empowerment outcomes that accrue to empowering communities include collective ability to maintain or improve quality of life of members and fostering of participatory skills among members (Zimmerman and Rappaport, 1988). The process leading to the creation of a community with equal opportunity to access resources and attain quality of life can be fast-tracked by organizations and individuals (Zimmerman, 1995).

2.4.2 Application of the empowerment theory to the current study

The tenets of the empowerment theory are applicable to the current study in some peculiar ways. Persons with neuropsychiatric disorders are vulnerable members in society due to their poor state of health, constraints faced in acquiring needed resources and social stigma (Mfoafo-M'Carthy, & Sossou, 2017). Consequently, persons with neuropsychiatric disorders have a sense of powerlessness, and less able to take charge of their own lives. This adversely affect their recovery and social inclusion. Attempts to revamp persons with neuropsychiatric disorders to take charge of their own lives and contribute meaningfully to their communities calls for empowerment approach.

The theory of empowerment is applied in SHGs to distinguish its typology of care from the professional-led mental health system. The theory relates the structure and role of SHGs to the relationship that exist among the three levels of analysis namely psychological, organizational, and community. SHGs represent an informal organization that provides a bottom-up structure for service delivery (Segal, & Hayes, 2016), and relates very well to the organizational level of analysis. As a non-hierarchical organization, SHGs should be adept in providing an atmosphere for individual members to interact with one another, share lived experiences about their disorders, assume roles and master social and leadership skills through participating in activities organized by the group, and these could empower individual members to recover and become integrated into society. This reflects the relationship between the

individual level of analysis and the organizational level of analysis. For instance, Sakyi (2015) stated that members of SHGs select their leaders from among themselves, and that the position rotates among members at different point in time. He noted also that SHGs organized programs such as educational outreach, and durbars which allowed members to participate.

Given that SHGs for persons with neuropsychiatric disorders in this study is community-based, the norms, relationships, structure, and the posture of institutions in the communities in which SHGs exist could facilitate the groups' activities and the recovery and social inclusion of the members. For instance, the willingness of community leaders, and corporate institutions and individuals to sponsor the activities of SHGs in the community could promote their capacities to embark of all activities that will offer members the opportunity to become empowered. Also, the norms and values of community members with respect to accepting SHG members or stigmatizing them could influence their capacity to function and invariably influence the empowerment outcome of the individual members. Put differently, SHGs and their members could embark on programs to systematically influence the various structures of the community to accept them, treat them equally as others, and work to collectively influence the wellbeing of persons with neuropsychiatric disorders in the community.

The empowerment theory conceptualizes that empowerment processes and outcomes are multi-dimensional which warrants the use of context-relevant outcome measures (Peterson & Zimmerman, 2004; Zimmerman, 1995). Although empowerment is a multi-dimensional concept, it depicts improvement in the quality of life of a person, organization, or community. The dimensions of empowerment which are being assessed in this study are recovery and social inclusion for persons with neuropsychiatric disorders. Thus, recovery and social inclusion are theoretically mapped to represent empowerment in the context of this study. The empowerment theory provides strong basis to infer that if SHGs in Greater Accra Region are truly

empowering and befitting agents in facilitating individual level empowerment, then they would be adept in promoting individual level empowerment outcomes. These outcomes are expected to manifest as recovery and social inclusion.

2.6.3 Relevance of the theory to the current study

Choosing the empowerment theory was not done by chance – some key considerations based on the tenets of the theory were made. The empowerment theory provides three levels of analysis which are interrelated. In fact, the theory emphasizes that both organizational and community contexts influence empowerment outcome in individuals. This provides basis for investigating how participation in SHGs, an organizational context facilitates individual level empowerment outcomes.

The theory provides explanation on the usefulness of SHGs to persons with neuropsychiatric disorders. For instance, it posits that informal groups (non-hierarchical organizations) provide favorable contexts for persons with neuropsychiatric disorders to become empowered than formal groups (hierarchical organizations). Inherent in this proposition is that the theory predicts a positive effect of participating in SHGs and empowerment outcomes, a proposition upon which the hypotheses of the current study were based. This prediction is important given that the existing literature is mixed the effect of SHGs on recovery and social inclusion outcomes. Thus, the theory provided a lens to predict the effect of SHGs on recovery and social inclusion.

The theory also gives room for context-relevant outcome measures to be used to assess empowerment outcomes. Differently put, the theory emphasizes that empowerment outcomes are fluid and can be better assessed in manner that will be relevant to a group, place, or in the scope of a research. Consequently, I am justified to assess outcomes of recovery and social inclusion in the context of this study.

2.5 Gaps in the literature

The literature reviewed have provided empirical and theoretical knowledge on the contributions of SHGs to the recovery and social inclusion of persons with neuropsychiatric disorders. The use of different methodologies and research design including qualitative, quantitative, and systematic review and meta-analysis help to provide detailed information about the topic. The qualitative studies were adept in documenting benefits of SHGs to participants, hence emphasizing their usefulness to participants. The quantitative studies were adept in reporting on the effectiveness of SHGs in promoting recovery and social inclusion using designs such as longitudinal, quasi-experiments, and randomized control trials. The systematic reviews and meta-analysis were successful in projecting the effectiveness of SHGs in facilitating recovery and social inclusion and evaluating the quality of the studies and their findings. The theoretical perspective section also provided tenets that explain the usefulness of SHGs and predicted their effectiveness in facilitating recovery and social inclusion outcomes for participants.

It is important to iterate that several gaps are present in the extant literature which need to be identified. While numerous studies have been conducted on the issue in different parts of the world, especially in the developed countries, only two (Cohen et al.; Sakyi, 2015) were found in the Ghanaian context, an observation which denotes dearth of literature on the topic. These Ghanaian studies provided in-depth description of the structure of SHGs and the benefits they provide to participants using the qualitative approach. Consequently, no quantitative measure of the benefits has been taken, a concern which the current study seeks to address. I recognize that little is known about SHGs in Ghana and that more in-depth information on the usefulness of SHGs is still needed to expand on the existing knowledge. I also recognize that a quantitative measure of these benefits should be taken to provide more generalizable information on the usefulness of SHGs in mental healthcare. More importantly, I recognize

that the effectiveness of SHGs in facilitating desirable outcomes (recovery and social inclusion) should be assessed to inform stakeholders better. In view of this I intend to use the mixed method approach to research to conduct this study in the Greater Accra Region of Ghana.

Another key observation from the literature is that quantitative studies that sought to examine the effectiveness of SHGs on recovery and social inclusion reported inconsistent findings. Some studies reported that SHGs significantly facilitate recovery and/or social inclusion outcomes, and others reported no effect on recovery and/or social inclusion outcomes for participants. The mixed results from effectiveness studies was emphasized by systematic review and meta-analysis (Lloyd-Evans et al., 2014; Pistrang et al., 2008). The mixed findings from the literature necessitates studies that assess the effectiveness of SHGs so that more precise conclusion can be drawn to inform policy and stakeholders.

It must be iterated that the existing studies focused on recovery as the key outcome variable and failed to include measures of social inclusion. This gives limited scope of outcomes that SHGs could facilitate. To emphasize the relevance of social inclusion as a desired mental healthcare outcome in Ghana, I am considering both recovery and social inclusion as outcome variables and hence adopt standardized scales to effectively measure them. This consideration is in line with the current focus on community-based approach to mental healthcare.

CHATER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This section describes the research methods chosen and the rationale for choosing them. It focuses on the study area, research design, population and sampling, data collection methods, instruments for data collection, data analysis, ethical considerations, and limitations of the study.

3.2 Study area

The study took place in the Greater Accra Region of Ghana. The Greater Accra Region hosts the Capital city of Ghana, Accra. In 2010, the region was populated by 4,010,054 people (Ghana Statistical Service, 2012). The region is touted as the wealthiest in Ghana because of the better economic opportunities it provides and its greater contribution to gross domestic product (GDP) (GSS, 2018). For instance, approximately 46% of employees in Ghana who receive regular wages and salaries are in Greater Accra Region (GSS, 2018). As the wealthiest region, which also hosts the capital city of Ghana, most of the residents in the region are people who have migrated from different part of the country to seek work. Life in Greater Accra Region is more individualistic compared to other regions in Ghana. As a result, informal care for persons with neuropsychiatric disorders is lower compared to areas where collectivist culture dominates. SHGs come in to provide heightened informal support through peer support to members. Thus, SHGs are likely to be more useful in the region. The common languages spoken in the region are English, Twi, and Ga. These languages are commonly used in social gatherings and public places such as the market, church, funeral grounds, and wedding. Both the formal and informal sector employs residents in the region.

The region hosts 2 of the 3 psychiatric hospitals in Ghana namely Accra Psychiatric Hospital and Pantang Psychiatric Hospital; 2 hospitals that deliver inpatient services, namely Valley View Clinic and Alberto Clinic; and has 23 hospitals that deliver out-patient services (Roberts, Asare, Mogan, Adjase, & Osei, 2013)). In 2017, a total of 53,235 attendance and 5,569 admissions were recorded in the outpatient and inpatient departments respectively in the mental health units and psychiatric hospitals in the region (MHA, 2018).

Figure 3.1 The map of Ghana depicting Greater Accra Region

BasicNeeds-Ghana, the NGO which is noted for facilitating the establishment of SHGs operate in the region. In addition, Mental Health Society of Ghana, a mental health user

association which supports the activities of SHGs has its Secretariate in the region. SHGs operate in some districts of the region (MHA, 2018). Given the existence of SHGs and adequate mental health hospitals/units in the region, it serves as a good place to conduct this study. This is important because, the basic parameters for comparison in this study are that participants should be receiving biomedical treatment and participant in the experimental group should belong to SHGs. Both requirements were easy to meet in this region. Also, the region is primarily an urban area which finds fit with my intention of situating this study in an urban context.

3.3 Research design

The mixed methods approach to research was used to guide this study. Figure 3.2 below provides a pictorial representation of the study design. The mixed methods approach features a pragmatic assumption, which Creswell and Plano Clark (2007) describe as the combination of quantitative and qualitative approaches to data collection and analysis in a single study. The key proposition of the mixed methods approach is that the combination of quantitative and qualitative approaches in a single study produce comprehensive empirical records and better understanding about a topic (Creswell & Plano Clark, 2007). Given this basis, the use of mixed methods enabled me to provide a a comprehensive information on the contribution and effectiveness of SHGs in facilitating recovery and social inclusion. This is important because, the issue has not been comprehensively studied in the Ghanaian context.

In designing a mixed methods study, Creswell (2009) proposes two fundamental considerations that must be made to inform the choice of a specific design. These are timing for data collection and analysis, and the weight placed on the two methods. In this study, data collection and analysis for both methods were done within the same time frame. Also, greater weight was placed on the quantitative method than the qualitative method. Consequently, the

concurrent embedded mixed methods design was used to guide this study. Creswell described the concurrent embedded design as one that uses:

> *One data collection phase, during which the quantitative and qualitative data are collected simultaneously. … The concurrent embedded approach has a primary method that guides the project and a secondary database that provides a supporting role in the procedure. Given less priority, the secondary method (qualitative or quantitative) is embedded, or nested, within the predominant method (qualitative or quantitative)* (pp. 214, 228).

This design is appropriate for this study because prior studies on SHGs conducted in Ghana used qualitative approach and have as a result provided some qualitative insight about the issue albeit this is in dearth quantity. This makes a quantitative study the most needed to expand empirical information about the issue. Also, placing greater weight on the quantitative study enabled me to effectively achieve the objectives set for this study. It also provided room to gather more current qualitative insight on the issue. In addition, this design enabled me to gather a comprehensive information on the topic than if only one method was used. In this study, the qualitative data was able to discover the mechanisms that informed causal relationship that the quantitative data established.

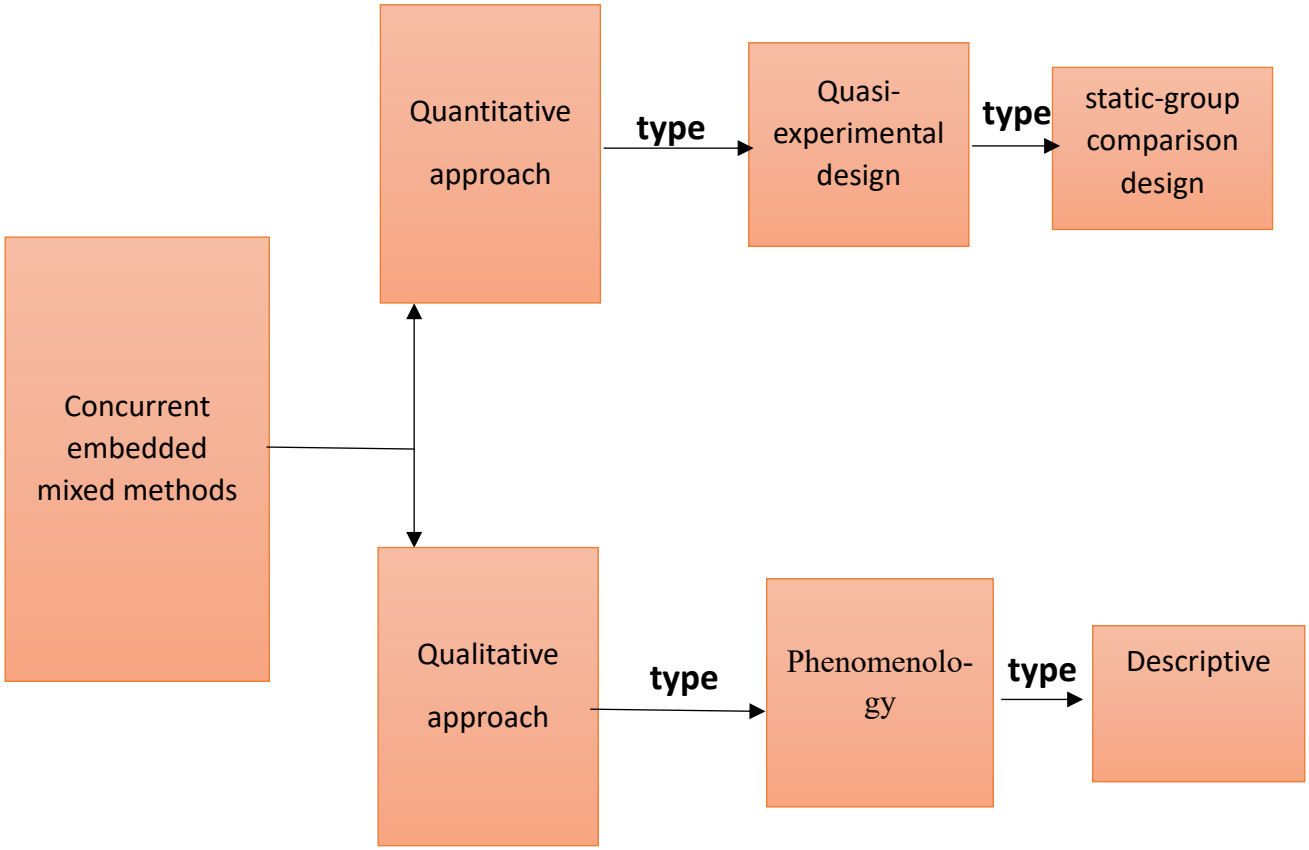

Figure 3.2 study design

Quantitative research design

Quasi-experimental design was used to conduct the quantitative aspect of the study. According to Thyer (2012) the quasi-experimental design is used in social work research to:

> *Compare the outcomes … for a group of clients who receive a novel intervention that is the focus of investigation, against the outcomes observed by a similar group of clients who received either no treatment or an alternative treatment (a comparison group)* (p.1).

Thyer (2012) further distinguishes that the type of quasi-experimental design which compares two groups where one receives an existing intervention, and the other does not is called the static-group comparison design. The static group comparison design is specifically appropriate for this study because two groups of persons with neuropsychiatric disorders, namely, those who belong to SHGs and those who do not were compared on outcome measures of recovery and social inclusion. Consequently, this design enabled me to compare the level of recovery and social inclusion for persons with neuropsychiatric disorders who belong to SHGs and those who do not. The static group comparison design is depicted in the Table below:

Table 3.1

Notation of the static group comparison design

Group 1: persons with neuropsychiatric disorders participating in SHGs	NR - X - O
Group 2: persons with neuropsychiatric disorders who are not in SHGs	NR - O

NR = No randomization; O= measurement; X= intervention.

This means that participants were not intentionally assigned to the two groups (NR). This is because the two groups existed naturally and was not created by the researcher. It is observed that that persons with neuropsychiatric disorders in group one (1) are participating in SHGs

(X-the intervention) and are measured on recovery and social inclusion measures (O). Those in group two (2) are non-SHG members and are measured on recovery and social inclusion measures (O) but did not participate in the intervention (X).

Qualitative research design

Descriptive phenomenology was used as the specific design for the qualitative aspect of the study. Phenomenology is useful in this study because, I intended to collect the qualitative data from only persons who have participated in SHGs before (either currently or in the past) and hence have a lived experience of the phenomenon. Descriptive phenomenology believes that common essence can be derived from the lived experiences of a group of people who have experienced same phenomenon (Wojnar & Swanson, 2007). Moreover, it is a suitable design for studying a phenomenon that has not been completely explained by research (Lopez & Willis, 2004).

Descriptive phenomenology was used because, the study sought to advance knowledge about the contributions of SHGs in relation to recovery and social inclusion, in a context where very little knowledge had been provided on the phenomenon. In addition, descriptive phenomenology aided me to extract a common essence (similar ideas) from the experiences of participants in a manner that limited the influence of my knowledge and experience as a researcher.

3.4 Study population

The study recruited persons with neuropsychiatric disorders (including those who are in SHGs and those who are not) who access primary mental health services from hospitals in the Greater Accra region. Persons with neuropsychiatric disorders were studied because the study examined the contributions and effectiveness of SHGs on recovery and social inclusion of persons with neuropsychiatric disorders.

3.5 Inclusion criteria

Quantitative

In this study, primary consideration was given to diagnosis that are dominant among SHG members. This is because the diagnosis of SHG members was used as a threshold for selecting non-SHG members. To enhance similarity between the two groups, some confounding variables were controlled using common criteria. Consequently, the participants in the study had to be:

- Diagnosed with schizophrenia, bipolar disorder, epilepsy, depression, or anxiety.
- An out-patient who has been on psychiatric medication for at least one year.
- Currently receiving biomedical treatment from a recognized mental health hospital/unit in the Greater Accra Region,
- 18 years or older. Persons who are 18 years or older were considered because they possess the legal capacity to self-determination. Therefore, they could give their consent to participate in the study.

Qualitative

The qualitative study sampled only SHG members. To participate in the study, one must:

- Be a volunteer, leader or member who currently participates or had participated before in SHGs in the Greater Accra Region. This means that former volunteers, leaders, and members of SHGs were included.
- Had participated in the activities of SHGs for at least 6 months. This was to ensure that all participants have enough experience to share about SHGs.
- Diagnosed with schizophrenia, bipolar disorder, epilepsy, depression, or anxiety. This was done to ensure that only persons with neuropsychiatric disorders participated in the study.

- An out-patient who has been on psychiatric medication for at least one year. This was to ensure that all participants are living in their homes and are taking their medications.
- Currently receiving biomedical treatment from a recognized mental health hospital/unit in the Greater Accra Region. This was to ensure that all participants access mental health services from Greater Accra Region.
- 18 years or older. This was to ensure that participants have the right to give consent.

3.6 Exclusion criteria

The study did not include persons with any other diagnosis apart from those specified in the inclusion criteria above. This was to ensure that the two groups have proportionally similar diagnosis. In addition, caregivers, family members, and mental health professionals were not included in this study. This is because the study sought to assess the impact of SHGs on the service users.

3.7 Sample size

Quantitative

A total of 162 persons with neuropsychiatric disorders participated in the quantitative study. This sample size was derived theoretically from the statistical power table developed by Cohen (1988). This table is useful when the primary focus of a study is to establish a statistical significance and the study population is difficult to estimate (Rubin & Babbie, 2011). Cohen established that given the level of significance, statistical power, and effect size, a statistically representative sample size can be determined. With reference to Cohen (1988), Rubin and Babbie (2011) establish that a statistical power of at least 0.80 is required for a study that seeks to draw statistical inference, and this (0.80) power is obtained with a sample of 84. They recommended a sample size of 90 or more to be enough to produce a significant statistical power. More specifically, Cohen (1988) reports that a sample size greater than 139 has a statistical power higher than 0.95 in detecting small effect size of 0.30. This means that with a sample size of 162, and at a confidence level of 95% (α=0.05), the current study has a probability of less than 5% (0.05) in committing Type II Error (the error committed when we fail to reject the null hypothesis when it is indeed false), when there is even a small effect size of (0.3).

Meanwhile, the sample size of 162 could not detect effect size that is less than 0.3, since a sample size of 194 is required to generate power of 0.80 to detect small effect sizes of 0.2 (Cohen, 1988). Thus, the sample size of 162 was enough to conduct this study only that I took the risk of committing Type II Error when the effect size is smaller than 0.3, which according to Rubin and Babbie (2011) is a meaningful risk that researchers may want to take. This is a meaningful risk I had to take because the study population was difficult to reach via telephone. In addition, face-to-face interview could not be practically possible for most of the participants given the risk that Covid-19 posed during the data collection period.

Qualitative

Qualitative data was collected from 13 participants. This comprised of two (2) volunteers, two (2) leaders, four (4) members, and three (3) inactive members. The choice of 13 participants was primarily based on data saturation: no new idea was coming from participants at the 12th and 13th interview. This is not strange because Boyd (2001) emphasized that a sample size of 10 is enough to reach data saturation in phenomenological study.

3.8 Sampling Procedures

Quantitative

One important consideration for selecting participants in this study was to ensure that the comparison group is similar to the intervention group. As a result, proportionally equal representation of diagnosis was of prime interest to me. I therefore, used the diagnosis of participants in SHGs as a benchmark for selecting the participants who are non-SHG members. Consequently, the multistage stratified sampling technique was used in selecting participants.

At the first stage, I selected institutions through which the study population could be reached. This was done with the use of non-probability sampling techniques. I purposively selected BasicNeeds-Ghana, since it is the organization which facilitated the establishment of the SHGs and as such could serve as the best gatekeeper. Thus BasicNeeds-Ghana could help me reach the SHG members. The convenience sampling technique was used to select Pantang Psychiatric Hospital and Ledzekuku Municipal Hospital. Apart from the fact that these hospitals have departments that provide out-patient mental health services, I received approval for data collection from them early enough so that I could plan well about data collection. I Selected the mental health hospitals/units based on convenience because all mental health hospitals in Greater Accra provide standardized biomedical treatment to participants. This means that participants do not differ based on where they receive biomedical treatment.

At the second stage, I liaised with BasicNeeds-Ghana, the district volunteers, and leaders of the SHGs to identify vibrant SHGs. This resulted in the selection of 16 SHGs. At the third stage, a list of all active SHG members who are persons with neuropsychiatric disorders (because some members are caregivers and have no diagnosis) with their respective telephone numbers, were compiled through the help of the volunteers and group leaders. The contact addresses were important because most of the questionnaires were administered via telephone call. A total of 109 list of members was obtained. Since the sampling frame obtained was almost as equal as the desired sample size of 100, coupled with the possibility that not all members on the list could be reached, I did not exclude any person on the list. The convenience sampling technique was applied to select all members on the list who could be reached or were available for participation.

In the third stage, the diagnosis of each person on the list was cross-checked from the Mental Health Society of Ghana, and few from the hospitals where they access services for accuracy. The proportion of each diagnosis identified from the sampling frame was used as a threshold for selecting participants from the comparison group. This comprised of 35% persons with epilepsy, 32% persons with schizophrenia, 19% persons with common mental disorders (depression or anxiety), and 14% persons with bipolar disorder.

At the final stage, selection of individual participants was done. Participants from the two groups were selected concurrently through the three institutions identified above. Participants at the Psycho OPD of Pantang Psychiatric Hospital were recruited through referrals from the Psychiatrists when clients come for review. This resulted in the selection of 34 participants. Referral technique was used because I did not get access to the list of participants with the specified diagnosis on account of the institution's ethical principles. Ledzekuku Municipal Hospital provided me with a list of 70 eligible persons, out of which 51 were finally recruited. The list detailed the names of service users, their diagnosis, and contact

addresses of their caregivers. No person in the sampling frame obtained from Ledzekuku Municipal Hospital was excluded before the interview, except for those who did not want to participate in the study, those who could not be reached and those who were found to be ineligible. Thus, the convenience sampling technique was used to select those who were available for the study. Given, that the list obtained from Ledzekuku Municipal Hospital contained the contact addresses of caregivers, I reached the participants through their caregivers. Similarly, the list of SHG members obtained from the leaders of the groups included the contact addresses of caregivers, through whom I reached the participants. A total of 85 participants were recruited from the Psycho OPD of Pantang Psychiatric Hospital and Ledzekuku Municipal Hospital. And a total of 77 SHG members participated in the study.

Qualitative

A combination of convenience and purposive sampling techniques were used to select the participants. Specifically, purposive sampling was applied to select the leaders and volunteers of the SHGs. Thus, volunteers and leaders who have served in their positions for many years (i.e. more than 5 years) were selected. This was to ensure that participants have rich experiences to share. The inactive members were selected based on availability. This was done because they were hard to find. Active members who have participated in the group for at least four (4) years were selected. Members who have participated in the group for at least four (4) years were considered to have rich experiences to share about the group. Beside the years, members who speak Twi or English was given priority to participate in the study. This was necessary because these are the two languages that I speak, hence I could engage in in-depth discussion with participants.

3.9 Sources of data

Primary data was used for analysis in this study. This is because, I find primary data as the most suitable form of data that can effectively provide answers to the research questions. Thus, primary data yielded fresh information generated directly from participants.

3.10 Data collection procedure

Quantitative

Greater part of the data was gathered after the restriction on social life in line with measures to prevent the spread of Covid-19 in Ghana had been mildly relaxed. In fact, all data from SHG members and participants from Ledzekuku Municipal Hospital were collected during this period. Thus, the data collection went through two phases: the period before covid-19 restrictive measures (March 03 -13, 2020), and the period after covid-19 restrictive measures had been mildly relaxed (July 01 – August 05, 2020).

At phase one, data was collected at the Psycho OPD of Pantang Psychiatric Hospital. The psychiatrists at the facility were informed about the eligibility criteria for selecting participants. Based on this, they referred clients to me in a seperate room to participate in the study. Based on the preference and literacy level of participants, the questionnaires were administered by myself or the participants. I administered approximately 90% of the questionnaires. A total of 34 participants were recruited at the end of phase one, and all these participants were non-SHG members.

At phase two, telephone interview was used to administer questionnaires to all the participants. In conducting the telephone interviews, I first called participants to introduce myself and the purpose of the research to the participants. Those who gave consent to participate were reassessed to ensure they qualified to participate. Thereafter, I reasoned with participants to fix a time for the interview. Finally, I called participants and I administered the

questionnaires. The languages used in administering the questionnaires were English, and Twi. However, there were few instances where participants could not speak any of these languages. For such participants, their caregivers served as interpreters to them. In all instances, either the caregiver or participants or both could speak English or Twi.

Qualitative

All qualitative data was collected via telephone interview. In conducting the telephone interviews, I first called participants to introduce myself and the purpose of the research to them. I then found out from participants, the most appropriate time to schedule the interview. I finally called participants on the scheduled time to conduct the interview. All interviews conducted were audio recorded. One round of interviews was conducted with each participant. All interviews were conducted in Twi or English. This was to ensure that I could engage in an in-depth discussion with participants since I speak these languages. On an average, each interview lasted for 42 minutes, with the maximum and minimum being 60 and 31 minutes, respectively.

3.11 Data collection Instruments

Quantitative instruments

Questionnaire was used as the tool for collecting data. Two sets of questionnaires, namely A and B were used. Set A was for participants who belong to SHGs and set B was for those who do not belong to SHGs. Each set of questionnaires was composed of four sections. The four sections in set A are: A - demographic characteristics, with 14 questions; B - information on recovery, with a 24-item scale; C - information on social inclusion, with a 16-item scale; and D - SHGs, recovery, and social inclusion, with 13 dichotomous questions. The four sections in Set B are: A - demographic characteristics, with 11 questions; B - information

on recovery, with a 24-item scale; C - information on social inclusion, with a 16-item scale; and D - opinion on mental health self-help groups, with 2 open ended questions.

Both standardized scales and self-developed questions were used in developing the questionnaires. Specifically, standardized measures of recovery and social inclusion were used in sections B and C for both sets of questionnaires. Detailed information of these measures is provided under measurement of dependent variables. The remaining questions were self-developed after reviewing relevant literature.

Qualitative instruments

Semi-structured interview guide was used as the tool for collecting data. Three sets of interview guides were developed: A – for the volunteers and leaders of the groups; B - for active members of SHGs; and C – for inactive members of SHGs (people who have stopped SHGs).

3.12 Measurement of dependent variables

In quantitative study, the use of questions, or valid and reliable measurement instrument is key to data collection. The two dependent variables, namely recovery and social inclusion were measured with existing scales.

Recovery

The Short version of the Recovery Assessment Scale (RAS), which is known as RAS-24 was adopted to measure mental health recovery. Salzer, and Brusilovskiy (2014) recounted that RAS was developed in the mid-1990s through qualitative analysis of the personal stories of persons diagnosed with neuropsychiatric disorders. This resulted in the development of the original 41-item RAS with each item rating on a 5-point Likert scale: 1-strongly disagree, 2-disagree, 3- not sure, 4-agree, and 5-strongly agree (Cavelti, Kvrgic, Beck, Kossowsky, & Vauth. 2012). A higher score indicates

In 2004, Corrigan, Salzer, Ralph, Sangster, and Keck (2004), used a sample of 1824 people in recovery in the USA to conduct exploratory and confirmatory analysis on the 41-item RAS. Their study confirmed 24 items as adequate to measure recovery. In addition, their study identified five subscales (factor structure) from the 24 items comprising (1) personal confidence and hope, with 9 items (α = .87); (2) willingness to ask for help, with 5 items (α = .84); (3) goal and success orientation, with 5 items (α = .82), (4) reliance on others, with 3 items (α = .74); and (5) no domination by symptoms, with 4 items (α = .74). It is important to note that Corrigan et al. (2004) did not report the Cronbach's Alpha for RAS-24 but the several studies on RAS-24 report it to range from 0.76 to 0.97, and test-retest reliably range from 0.65 to 0.88 (Salzer & Brusilovskiy, 2014). The five-factor structure of RAS-24 has been confirmed in Japanese, Chinese, and Australian populations (Chiba, Miyamoto, & Kawakami, 2010; McNaught, Caputi, Oades, & Deane, 2007; Mak, Chan, & Yau, 2016).

Construct validity of RAS-24 has been confirmed as it correlated positively with measures of similar constructs including the Herth Hope Index, which measures hope; Empowerment scale, which measures empowerment; Resilience Scale, which measures resilience; Short-Form Health Survey (SF-8), which measures quality of life; and correlated negatively with the Behavior and Symptom Identification Scale (BASIS-32), which measures psychiatric symptoms and functional impairment (Mak et al., 2016). A systematic review conducted by Cavelti et al. (2012) confirmed that RAS has good construct validity and reliability. In addition, RAS is easy to administer, and is tailored towards accessing persons who use mental health services (Cavelti et al., 2012; Sklar et al., 2013). In fact, RAS has been ranked as the most suitable measure of personal recovery (Cavelti et al., 2012; Salzer, & Brusilovskiy, 2014; Sklar et al., 2013).

No item on this scale was removed. Also, no modification was made to the items on the scale. This is because all the items on the scale were simple to understand and easy for

participants in the current study to relate to. Some of the statements in the instrument reads "I have goals in life that I want to reach", "I like myself", "my symptoms interfere less and less with my life", "I ask for help when I need it", and "I have people I can count on". In this study, the Cronbach's Alpha for the total scale was 0.82, which indicates good internal consistency. The internal consistency for the subscales were also within the acceptable range of greater than 0.5 (Mensah, 2016; Nunnally, 1967). They were 0.66 for Personal Confidence and Hope, and Reliance on Others; 0.83 for Willingness to Ask for Help; 0.76 for Goal and Success Orientation; and 0.77 for No Domination by Symptom.

Social inclusion

The concept of social inclusion is multidimensional and possess a challenge when it is to be measured, and hence choosing a measure of the concept is best influenced by context and focus of a study (Chan et al., 2015; Secker et al., 2009). In view of this, the Social Inclusion Scale (SIS) was adapted to measure social inclusion. This scale is composed of constructs that the intervention (SHG) can influence if it is effective, other than structural factors that may be influenced greatly by other macro factors. Thus, the scale has good face validity in the context of this study.

The SIS was developed by Secker et al. (2009) as a measure of social inclusion for mental health service users. The original scale composed of three subscales namely social isolation (SI), social relations (SR), and social acceptance (SA) (Secker et al., 2009), and these have been confirmed by Wilson and Secker (2015). The scale is rated on a 4-point Likert scale: 1-not at all, 2-not particularly, 3-yes a bit, and 4-yes definitely. A low score indicates lower level of social inclusion, and a higher score indicates high level of social inclusion

Internal consistency was reported to be good by the original author for the composite scale **(**$\alpha = 0.85$), and the subscales: SI (α=0.76), SR (α=0.76), and SA (α=0.70) (Secker et al.,

2009). Wilson and Secker (2015) validated the SIS and reported that the composite scale has good internal consistency (α = 0.80) and test-retest reliability (r = 0.80). Although the authors reported good test-retest reliability for all the subscales (r=0.80, 0.71, and 0.71 for SI, SR, and SA respectively), internal consistency was not satisfactory for all: SI (α=0.65), SR (α=0.71) and SA (α=0.54) given that the desired threshold for Cronbach's Alpha is 0.70 (Hair, Black, Babin & Anderson, 2010). As indicated already, obtaining a complete construct validity is just not feasible for fluid constructs like social inclusion. However, convergent validity, a partial component of construct validity has been proven as it correlated positively with the Empowerment Measure (Secker et al., 2009).

The scale has a total of 17 items, but the sum of the subscales gives 19 items. This is because two items on the scale correlated with two subscales at a time and they were included in the respective subscales (Secker et al., 2009; Wilson & Secker, 2015). One of the items: "I have felt terribly alone and isolated", appeared to be too harsh to be exposed to participants and I realized any attempt to tone it down would change the original meaning, so I dropped it. This is not problematic because Secker et al. (2009) recommended that SIS should be used when necessary modifications have been made to suit the context. In addition, Wilson and Secker (2015) dropped one item of the scale to suit the population they studied when they validated the scale and that did not obstruct the factor structure of the original scale.

I modified three items by adding context-relevant examples to items to enhance understanding of those items and to enable participants relate to the items very well. The item "I have been out socially with friends" was updated to "I have been out socially with friends (for example to the wedding, funeral, stadium, and clubs). The item "I have done some cultural activities" was updated to "I have done some cultural activities (for example gone to funeral, festival, and wedding)"; and the item "I have felt free to express my beliefs" was updated to "I have felt free to express my beliefs (for example political and religious). Some of the statements

in the instrument are: “I have been involved in group, club, or organization that is not just for people who use mental health services”, “I have felt accepted by my neighbors”, and “I have felt that I am playing a useful part in society”.

The composite scale used in this study had 16 items, SI had 4 items, SA had 5 items and SR had 9 items. The Cronbach’s Alpha of the composite scale in the current study was 0.83, which indicates good internal consistency. The Cronbach’s Alpha for the subscales were: SI (0.73), SA (0.73), and SR (0.52). This indicates that SI and SA had acceptable internal consistency, but SR had a poor internal consistency based on the commonly accepted rule of thumb by George and Mallery (2003) that α: ≥ 0.9 – Excellent, ≥ 0.8 – Good, ≥ 0.7 – Acceptable, ≥ 0.6 – Questionable, ≥ 0.5 – Poor, and < 0.5 – Unacceptable. However, this is not problematic for two reasons: 1) the factor structure for the scale is not likely to be obstructed because, none of the subscales or the composite scale has unacceptable score for internal consistency; 2) a Cronbach’s Alpha greater than 0.5 is tolerated as acceptable for use when a scale is adapted for use in a new context for the first time (Mensah, 2016; Nunnally, 1967).

3.13 Measurement of independent variables

The two independent variables, namely participation in SHGs and non-participation in SHGs were measured using leading questions. The questions were found on some context relevant understanding of the variables. Four dichotomous (leading) questions were asked:

1. Have you heard of mental health SHG before?
2. Have you attended SHG meetings before?
3. Were you able to attend at least half of SHG meetings within the last 6 months prior to March 2020?
4. Have you registered as a member of the SHG?

Participation in mental health self-help groups

The independent variable, participation in SHGs was measured as:

1. Being a registered member of a SHG for at least 6 months and;
2. Having attended at least 50% of the meetings and activities organized by the group between September 2019 and March 2020.

Non-participation in mental health self-help groups

Non-participation in SHGs was measured as being unregistered member of any mental health SHG and having not participated in their meetings before.

3.14 Data analysis and explication

Quantitative

The quantitative data was analyzed with the assistance of the Statistical Package for Social Sciences (SPSS) version 23. Both descriptive and inferential statistics were used. Specifically, the Independent Sample T-test was used to conduct the inferential analysis, while percentages, frequencies, means, and standard deviations were used for the descriptive analysis. Rubin and Babbie (2005) state that Independent Sample T-test is appropriate to use when one wants to compare the effect of two nominal independent variables on a dependent variable. Also, T-test is appropriate for use when a researcher intends to compare the means of two groups on an interval or ratio measure (Anastas, 1999). Since I compared means scores of SHG members with non-SHG members in order to assess the effect of SHGs on persons with neuropsychiatric disorders, the Independent Sample T-test was appropriate for this study.

The data analysis went through series of five main steps which are outlined below.

1. Each questionnaire was given a numerical code.
2. Responses on the questionnaires were entered into the SPSS software.

3. The data was cleaned manually.
4. The final analysis was run to produce an output data.
5. The output data was transferred to Microsoft Word for data presentation and further analysis.

Although SPSS was used to facilitate all mathematical computations, the software has no feature to compute effect sizes. In view of this, values for effect sizes were computed manually using the formular for calculating Cohen's d: $\frac{M1 - M2}{\sqrt{\frac{(n1-1)SD1^2+(n2-1)SD2^2}{(n1+n2)-2}}}$ (Cohen, 1988). In simple terms, this formular can be stated as the differences in the means of the two groups, divided by the pooled standard deviation of the groups. The numerator depicts differences in the means of the groups, and the denominator depicts the pooled standard deviation of the two groups. From the formular above, M1 = mean score of SHG members; M2 = mean score of non-SHG members; n1 = sample size of SHG members; n2 = sample size of non-SHG members; SD1 = standard deviation of SHG members; and SD2 = standard deviation of non-SHG members. Since SPSS generates all the raw values from the t-test table, I imputed the values in their respective places in the formular for each of the relevant scales and subscales to obtain the effect sizes.

Qualitative

The audio-recorded data was transcribed verbatim. The transcription was done manually by listening to the audio and typing it into Microsoft Word document. All interviews conducted in Twi were translated into English and typed accordingly during the transcription process. The interviews were transcribed on the same day or the next day from the time they were conducted. This was done to ensure that the data does not pile up to put strain on me. The transcribed data was cleaned to ensure that texts reflect a good grammar.

Thematic analysis was used to explicate the qualitative data. Thematic analysis involves the identification, classification and reporting of common patterns of ideas contained in a data **(**Braun & Clarke, 2006). This type of qualitative analysis is fitting for this study because it allowed me to derive core ideas (themes) from the experiences that participants shared. In conducting the thematic analysis, the seven steps espoused by Colaizzi (1978), and which has been recommended by Wojnar and Swanson, (2007) for explicating data in descriptive phenomenology was adopted. The steps are:

1. Familiarization through reading and rereading of the transcripts of each respondent.
2. Selecting relevant statements that fall within the scope of the phenomenon under consideration.
3. Formulating meanings for the relevant statements.
4. Patterning the meanings into clusters of themes and crosschecking it with the original stories of participants to ensure that they are in harmony.
5. clustering themes and crosschecking it with the original stories that illuminate the common essence of the experiences of participants, a framework which is made up of the rich stories of each participant (Wojnar & Swanson, 2007).
6. Validating the findings by going back to some participants to find out about how the description ties in with their experiences.
7. Updating the descriptions with changes that arise from the member checking to produce a final description that represents the common essence of the phenomenon. In presenting the findings, the themes were mapped with the existing knowledge which was used to formulate the questions in the questionnaire. Thus, the deductive approach to data analysis was used.

3.15 Ethical considerations

Research that involves the study of human subjects warrants adherence to ethical principles, and this is even needful when the study population is a vulnerable group such as persons with neuropsychiatric disorders. In view of this, I abided by all key ethical principles, comprising informed consent, anonymity, privacy and confidentiality, prevention of harm, and plagiarism in this study. I received ethical approval from the Ethics Committee for Humanities (ECH), University of Ghana before going to the field to collect data.

Informed consent was sought from the leadership of the three institutions where participants were recruited from as well as from each participant. To the institutions, I wrote a letter with attachment of the thesis proposal, informed consent forms, and the ethics approval letter to seek their consent. This means that the leaders of the institutions were informed about the purpose of the study including potential benefits and harms for participants. To the study participants, an informed consent form which details the purpose, benefits, and harms of the study was presented and thoroughly explained to each participant. Participants were also informed about their right to withdraw their participation at any point during data collection.

The ethical principle of Privacy and Confidentiality was adhered to. The real identities of individual participants, as well as names of SHGs were camouflaged with the use of pseudonyms. Privacy during data collection was ensured. All face-to-face interviews conducted at the Psycho OPD of Pantang Psychiatric Hospital was done in a consulting room which was dedicated to me for the purpose of data collection. For participants interviewed via telephone, I ensured that they were at a place that was devoid of third parties, and most of them were interviewed while they were at home. All audios, transcripts, and answered questionnaires were kept from the reach of third parties. Specifically, data in softcopy were kept on my personal laptop and in my Google Drive Account both of which are sealed with passwords. The data in hardcopies were stored in my personal suitcase.

I revised my data collection methods from face-to-face interviews to telephone interviews as a response to the sudden spread of covid-19 in Accra. This action was meant to protect myself and my study participants from contracting the virus, and hence controlled harm associated with face-to-face interview. In addition, I demonstrated intellectual honesty by providing relevant references for all secondary sources of information used in the study.

3.16 Limitations of the study

The type of quasi-experimental design used in this study did not take an initial measure of participants nor did random assignment of participants to the groups. This raises questions about similarity between the experimental group and the comparison group. I ensured that participants in the two groups had similar diagnosis, were all on biomedical treatment, and had all been on biomedical treatment for at least 1 year. These extraneous variables were controlled before data collection using inclusion and exclusion criteria. In addition, after data collection, it was observed that participants in the two groups were similar on key socio-demographic variables including sex, religion, education, and employment status.

The responses from the study participants could be doubted for fear that their neuropsychiatric disorders could compromise their ability to respond effectively to the questions. I recruited persons with neuropsychiatric disorders who were out-patients and had been on biomedical treatment for at least one year. The study population was not in a relapse episode as they lived in their communities and had capacity to respond effectively to the questions. In addition, I postponed interviews with persons who were in their relapse state at the first time I contacted them, followed up on them and interviewed them when their caregivers affirmed that they have recovered from the relapse. As a social worker, I encouraged such participants to take their medications since all of them were already on medication. I also encouraged the caregivers to give out their best in ensuring a quality caregiving services.

Probability sampling could not be used in the recruitment process for the quantitative participants for the study. In addition, due to the impact of Covid-19 (greater part of the data was collected during the outbreak of Covid-19, from July to August), most people in the study population, especially those who do not use personal mobile phones were difficult to reach. These facts indicate that the data used in this study may not be representative of the population. However, the telephone numbers of relatives, caregivers, and SHG leaders were used as a medium to reach most participants which made it more possible to reach some people who did not have a personal mobile phone. SHG members were recruited from 16 groups which provides sufficient basis for representation of the population. Also, non-SHG members were recruited through the two mental health hospitals and this indicates that participants were more likely to come from different communities, giving little concern about representation issues.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents the findings for the entire study. this is broadly organized into four sections. The first section presents data on the sociodemographic characteristics of participants; the second, third and fourth sections present results for objective one, two and three of this study, respectively.

4.2 Socio-demographic characteristics of participants

Given that this study made use of the mixed methods approach, two sets of socio-demographic data were collected: one for the quantitative study and the other for the qualitative study. Results are therefore presented separately for the two methods beginning with the quantitative.

4.2.1 Socio-demographic characteristics of the quantitative participants

This section presents the socio-demographic details of participants by group. Socio-demographic details for both groups comprising sex, age, education, religion, marital status, employment status, years lived on medication, and type of neuropsychiatric disorders are presented in Table 4.1. For each variable, the frequency and percentage distribution of SHG participants, non-SHG participants, and for both groups are provided. The p-value denoting the level of significance of the observed differences between the two groups for each variable is also presented in the Table. Additionally, two socio-demographic characteristics exclusive to only participants in SHGs are presented in Table 4.2. They are duration in SHGs, and participation in SHG meetings. Each socio-demographic variable is interpreted separately. First, I provide the total number or percentage of each category, then I proceed to compare the

distribution of the variable between the two groups, and finally report the level of significance for the observed differences between the groups. For the socio-demographic variables exclusive to participants in SHGs, I provide a simple description within the group without any

Table 4.1

Sociodemographic characteristics of quantitative participants by group

Socio-demographic variables	SHG members (N = 77)	Non-SHG members (N = 85)	Total (N = 163)	*P* Value
	Frequency (%)	Frequency (%)	Frequency (%)	
Sex				
Male	26 (32.5)	25 (29.4)	51 (31.3)	.590
Female	52 (67.5)	60 (70.6)	112 (68.7)	
Age				
18-39	37 (48.0)	44 (51.8)	81 (50.0)	.008**
40-59	26 (33.8)	38 (44.7)	64 (39.5)	
60 and above	14 (18.2)	3 (3.5)	17 (10.5)	
Education				
No education	2 (2.6)	6 (7.1)	8 (4.9)	
Basic School	49 (63.6)	41 (48.2)	90 (55.6)	.187
Senior High School	17 (22.1)	28 (32.9)	45 (27.8)	
Tertiary	9 (11.7)	10 (11.8)	19 (11.7)	
Religion				
Christian	68 (88.3)	77 (90.6)	145 (89.5)	.334
Muslim	9 (11.7)	6 (7.1)	15 (9.3)	
Traditional	-	2 (2.3)	2 (1.2)	
Marital status				
Single	53 (68.8)	46 (54.1)	99 (61.1)	.044*
Married	19 (24.7)	23 (27.1)	42 (25.9)	
Married before	5 (6.5)	16 (18.8)	21 (13.0)	

Employment status				
Employed	4 (5.3)	10 (11.8)	14 (8.7)	.131
Self employed	37 (48.7)	30 (35.3)	67 (41.6)	
Unemployed	35 (46.0)	45 (52.9)	80 (49.7)	
Diagnosis				
Epilepsy	27 (35.0)	24 (28.2)	51 (31.5)	.805
Schizophrenia	22 (28.6)	27 (31.8)	49 (30.2)	
Depression and anxiety	16 (20.8)	18 (21.2)	34 (21.0)	
Bipolar disorder	12 (15.6)	16 (18.8)	28 (17.3)	

*p < .05; **p < .01. N of all variables was 77 and 162 for SHG members and the total columns, except for employment status which N was 76 and 161, respectively.

Table 4.2

ANOVA score for age and marital status on measures of recovery and social inclusion

	Recovery		Social Inclusion	
	F	P-value	F	P-value
Age	.72	.487	1.805	.168
Marital status	.131	.877	1.963	.144

4.2.1.1 Sex

Table 4.1 provides details about the sex distribution by group. Out of the total respondents, a little above two-third (68.7%) were females and a little below one-third (31.3%) were males. SHG members had slightly higher proportion of males (32.5%) than non-SHG members (29.4%). Consequently, the proportion of non-SHG members who were females (70.6%) was a little higher than SHG members (67.5%). A chi-square test revealed no differences in the sex distribution between the groups X^2 (2, N = 162) = 6.3, p > .05.

4.2.1.2 Education

Table 4.1 provides information about the educational status of participants. Participants with no education constituted 4.9 percent of the total respondents. Basic education (both Primary and Senior High School) stood out as the dominant level of education (55.6%) attained by participants. This was followed by Senior High School (27.6%), and tertiary (11.7%). SHG members who had attained no education (2.6%) were less compared to non SHG members (7.1%). However, SHG members with Basic education (63.6%) were quite more than non-SHG members (48.2%). For participants with Senior High School education, non-SHG members (32.9%) were almost 10 percent more than those in SHGs (22.1%). Moreover, the proportion of SHGs with tertiary education (11.7%) were almost the same as non-SHG members (11.7%). A Chi-Square test (excluding the no education category) proved that the observed differences between the educational levels of participants in the groups was not significant X^2 (2, N = 154) = 3.5, p > .05.

4.2.1.3Religion

Table 4.1 provides details of the religions that participants are affiliated to. Greater majority of participants were Christians (89.6%). This was followed by Muslims (9.2%), and then traditionalists (1.2%). The proportion of SHG members who are Christians (88.3%) was not so different from non-SHG members (90.6%). For participants who are Muslims, SHG members (11.7%) were slightly more than the non-SHG members (7.1%). All 2 participants who were affiliated to the traditional religion are non-SHG members. A Chi-Square test run for only Christian and Muslim categories revealed that the observed differences in the religious affiliation of the two groups was not statistically significant X^2 (1, N = 160) = .94, p > .05.

The Chi-Square test excluded the Traditional Religion category because the expected count in this category was less than 5. Meanwhile, Chi-Square test can be run for cells that have expected counts of at least 5.

4.2.1.4 Marital status

Table 4.1 presents information about the marital status of participants. Out of the total number of participants, a little less than two-third (61.1%) were single, about a quarter (25.9%) were married, and a little above one-tenth (13.0%) had married before but were divorced, separated, or widowed. The proportion of SHG members who were single (68.8%) were more than those who are not in SHGs and were single (54.1%). More non-SHG participants (27.1%) were married compared to participants in SHGs (24.7%) who were married. Also, non-SHG participants who had married before (divorced, separated, or widowed) were about three times (18.8%) more than SHG participants (6.5%). The Chi-Square test provides evidence that the observed differences between the marital status of the groups was significant X^2 (2, N = 162) = 6.3, $p < .05$. To determine the need or otherwise to control the effect of marital status on the dependent variables, One Way Analysis of Variance (ANOVA) was conducted and table … depicts the results. It was found that marital status has no effect on recovery [F (2, 159) = 1.31, $p > 0.5$] and social inclusion [F (2, 159) = 1.96, $p > 0.5$]. This means that marital status has no effect on recovery and social inclusion. Thus, although SHG members differ significantly from non-SHG members in terms of marital status, this difference is not material in influencing the outcome variables on which the two groups will be compared.

4.2.1.5 Employment status

Table 4.1 provides information about the employment status of participants. Out of the total participants, almost half (49.7%) were unemployed, 41.4 percent were self-employed, and

8.6 percent were employed. The proportion of non-SHG participants who were unemployed (52.9%) was slightly more than SHG participants who were not employed (46.0%). The proportion of SHG participants who were self-employed (48.7%) were comparatively more than non-SHG participants who were self-employed (35.3%). Meanwhile, non-SHG participants who were employed (11.8%) were marginally more than SHG participants (5.3%) who are employed. A Chi-Square test conducted proved that the observed differences between the employment status of the two groups was not statistically significant X^2 (2, N = 161) = 4.1, p > .05.

4.2.1.6 Diagnosis

Table 4.1 provides the diagnosis of participants. Out of total participants, a little below one-third (31.5% and 30.2%) lives with epilepsy and schizophrenia, respectively. About a fifth (21.0%) live with depression or anxiety, and a little below one-fifth (17.3%) live with bipolar disorder. With respects to participants who live with epilepsy, the proportion of SHG members (35.0%) was marginally more than non-SHG members (28.2%). But for schizophrenia, non-SHG participants (31.8%) were a little more than the SHG members (28.6%). The proportion of SHG members who live with depression or anxiety (20.8%) was not so different from non-SHG participants (21.2%). There were slightly more non-SHG participants (18.8%) than SHG participants (15.6) who live with bipolar disorder. Evidence from a Chi-Square test concluded that the observed differences between the diagnosis of the groups was not statistically significant X^2 (3, N = 162) = 9.8, p > .05.

4.2.1.7 Age

Information on the age distribution of participants in SHGs and non-SHGs is presented in table 4.1 above. Exactly half of the participants were within the ages of 18 – 39 years. A

little above a third (39.5) were within the ages of 40 – 59, and about a tenth (10.5%) were aged 60 years and above. Comparatively, the proportion of SHG members (48.0%) who were within the youthful age bracket of 18-39 was slightly less than non-SHG members (51.8%). Similarly, the proportion of SHG members (33.8%) within the ages of 40-59 was less than non-SHG members (44.7%). However, SHG members (18.2%) aged 60 years and above were more than non-SHG members (3.5%). A Chi-Square test revealed that SHG participants were significantly older than non-SHG participants X^2 (2, N = 162) = 9.6, $p < .05$. ANOVA was conducted to determine the effect that age makes on recovery and social inclusion. It was found that age has no significant effect on recovery [F (2, 159) = 0.72, $p > 0.5$] and social inclusion [F (2, 159) = 1.81, $p > 0.5$]. This means that the differences between the ages of SHG and non-SHG members does not confound comparison between the groups on measures of recovery and social inclusion.

Table 4.3

Socio-demographic characteristics of quantitative respondents exclusive to SHG members (N=78)

Socio-demographic characteristics	Frequency	Percentage
Duration in SHG		
1-5 years	46	59.0
6-10 years	14	17.9
11 years and above	18	23.1
Level of Participation		
About half	5	6.4
More than half but not all	15	9.2
All	58	74.4

4.2.1.8 Duration in Self-help groups

Table 4.2 provides details about the number of years participants in SHGs have been a member to the group. Majority of them (59.0%) have been members for 5 years or less, a little below a quarter (23.1%) have been members for at least 6 years and at most 10 years, and a little below a fifth (17.9%) have been members for at least 11 years. On an average, participants have been members for approximately 6 years and 4 months (6.37 years). The least years one has been a member to a SHG was 1 and the highest was 15.

4.2.1.9 Level of participation

Table 4.2 provides information on the level of participation in SHG meetings by respondents. Approximately three-quarter (74.4%) of respondent do attend all meetings organized by the group, about a tenth (9.2%) attend more than half but not all (most) meetings of the groups, and a little above a twentieth (6.4%) attend half of the meetings of the group.

4.3 Socio-demographic profile of the qualitative participants

This section provides details about the social and demographic characteristics of the SHG members who were interviewed for the qualitative study. Table 4.3 provides a summary of the socio-demographic characteristics of the participants. The total number of participants were thirteen. There were more females (10) than males (3), and the ages of participants ranged from 28 to 75 years. Three (3) participants had not attended school at all, six (6) had attained Junior High school education, and four (4) had attained Senior High School education. In terms of religious affiliation, six (6) were Christians and seven (7) were Muslims. For marital status, two (2) were single, eight (8) were married, and three (3) were widowed. The least year participants had belonged to SHG was two (2) and the highest was fifteen (15). There were two (2) volunteers, (1 being former and 1 incumbent), two (2) leaders, four (4) members, and three (3) inactive members.

Table 4.4

Socio-demographic profile of qualitative participants

Participant	Sex	Age	Education	Religion	Marital status	Duration in SHG	Status in SHG
Mary	Female	52	JHS	Christian	Widowed	2 Years	Inactive Member
Niusha	Female	64	JHS	Muslim	Widowed	10 Years	Leader
Aliya	Female	52	SHS	Muslim	Married	10 Years	Member
Fatima	Female	65	None	Muslim	Married	8 Years	Inactive member
Nadia	Female	28	None	Muslim	Married	4 Years	Member
Lukaya	Female	46	None	Muslim	Married	6 Years	Inactive member
David	Male	67	SHS	Christian	Married	12 Years	Former Volunteer
Esther	Female	75	JHS	Christian	Widowed	15 Years	Leader
Akosua	Female	42	JHS	Christian	Single	4 Years	Member
Borketey	Male	34	JHS	Christian	Single	4 Years	Leader
Khadija	Female	36	JHS	Muslim	Married	4 Years	Member
Hagar	Female	60	SHS	Christian	Married	15 Years	Leader
Okatakyie	Male	58	SHS	Muslim	Married	14 Years	Volunteer

4.4 Ways in which SHGs facilitate recovery and social inclusion

The first objective sought to explore the ways in which SHGs facilitate recovery and social inclusion of persons with neuropsychiatric disorders. Both quantitative and qualitative data were collected toward achieving this objective**.** Results are presented first for the quantitative followed by the qualitative.

4.4.1 Quantitative results

The quantitative data was collected from only SHG participants (N = 77). Thirteen dichotomous statements were presented to participants to identify those that are applicable to them with a "yes" answer and to exclude those that are not applicable to them with a "no" answer. Basically, a statement that receives approval from more than 50 percent of respondents were considered as a useful way in which SHGs promote recovery and social inclusion of members. The thirteen statements have been reorganized under six main pathways namely promotes proper management of the disorder, promotes social integration, social support, improved ability to cope with stigma, and renewed sense of identity.

In addition, one open ended question which reads "Please state other ways (if any) that mental health self-help group has facilitated your recovery and social inclusion"? was asked to adequately explore the ways in which SHGs facilitate recovery and social inclusion of participants. However, all responses provided through the open-ended questions overlapped with one of the dichotomous statements. Results is presented for each of the key pathways.

4.4.1.1 Promotion of the proper management of the disorder

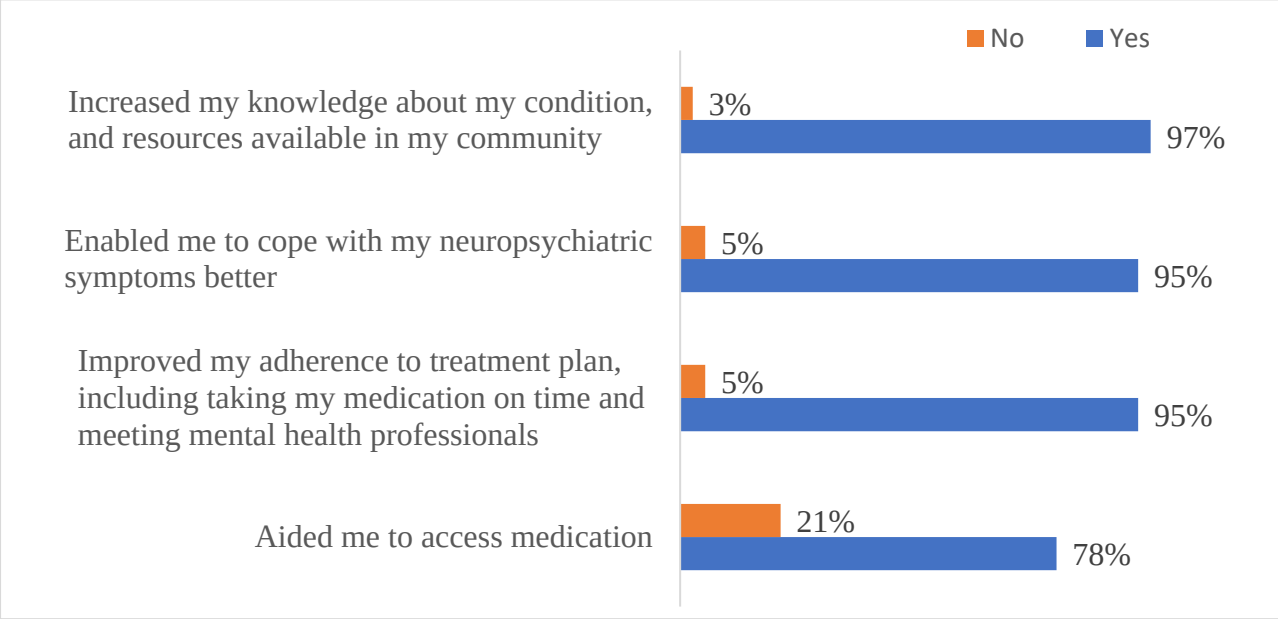

Figure 4.1. Response for four statements under the promotion of the proper management of the disorder (N = 77)

Four of the total statements were asked to assess the ways in which SHGs promote proper management of participants' neuropsychiatric disorders as provided in fig. 4.1 above. This is because recovery requires living a satisfying life even with the presence of neuropsychiatric disability (Anthony, 1993; Deegan, 1988). Interventions that provide life skills, access to information and resources required to cope with the disorder and bring it under control such that the person can perform his/her social functioning are recovery oriented.

All the four statements received a positive response ranging from 78 percent to 97 percent. The first statement reads, SHG has "aided me to access medication" This was approved by majority (78%) of the respondents, with only 17 (22%) answering no. Thus, almost four-fifth of respondents have been supported by the SHG in getting medications before. The second and third statements read SHG has: "improved my adherence to treatment plan, including taking my medications on time and meeting mental health professionals" And "enabled me to cope with my neuropsychiatric symptoms better" These positive worded

statements were affirmed by greater majority (95%) of respondents, with only few (5%) disproving the usefulness of SHG in these ways. The final statement on this reads SHG has "increased my knowledge about my condition, and resources available in my community". This positive worded statement received an overwhelming confirmation (97.4%) from respondents, with just a few (2.6%) of them discrediting the usefulness of SHG in this way.

4.4.1.2 promotion of social integration

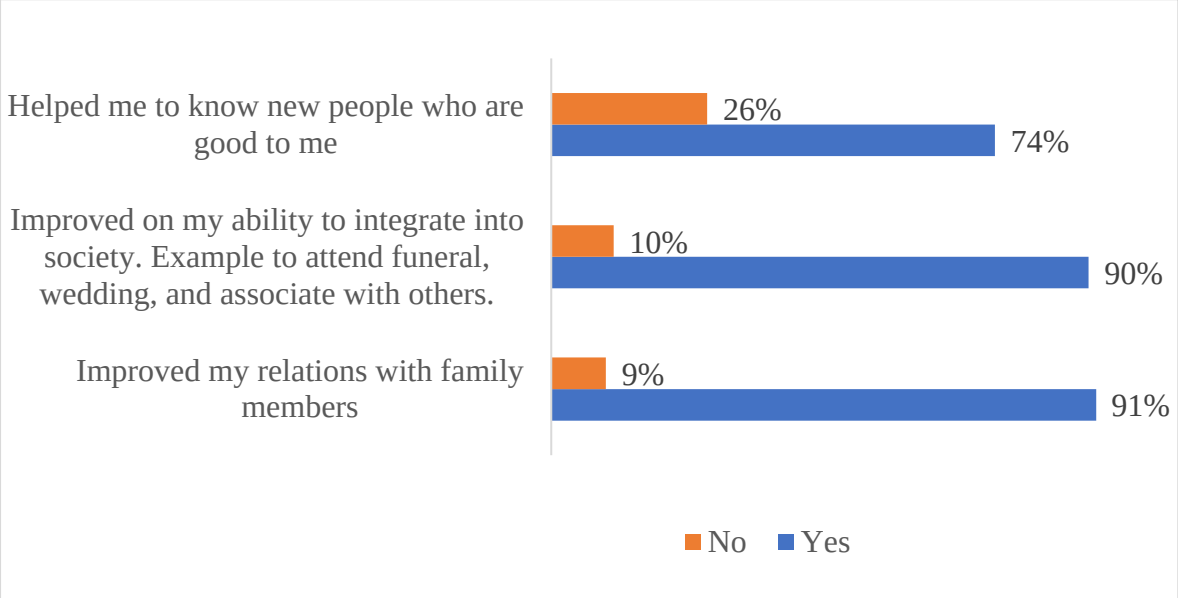

Figure 4.2. Response for three statements under Promotion of social integration (N = 77)

Social integration is a key indicator of social inclusion and are often time used interchangeably. Social integration is one of the desired outcomes of mental health interventions in Ghana (MHA, 2018). Statements that pertain to improvement in social interaction with others including family members, peers, and people in the community as well as improvement in the level of social activities and events are captured under this pathway. Three major statements come under this and all statements were approved by majority of participants. Figure 4.2 above depicts the responses of participants in percentages.

The first statement under this pathway reads SHG has "improved my relations with family members". This was confirmed by greater majority (91%) of respondents, with a little less than a tenth (9%) discrediting the usefulness of SHG in this way. The next statement reads SHG has "improved on my ability to integrate into society. Example to attend funeral, wedding, and associate with others". This was approved by majority (90%) of respondents. The third statement was that SHG has "helped me to know new people who are good to me". This statement sought to no whether SHGs aid members to expand their social network. Majority of respondents (74%) indicated that SHG has helped them through this way.

4.4.1.3 Social support

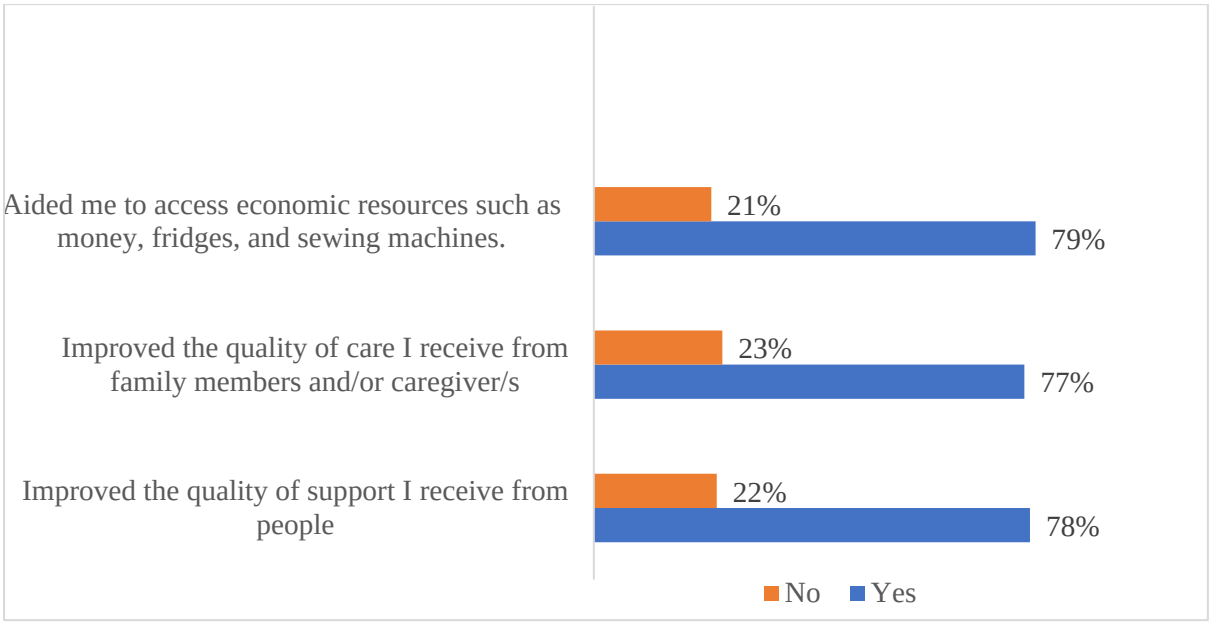

Figure 4.3. Response for three statements under increased social support (N = 77)

Receiving quality support from others is a key facilitator of recovery and social inclusion (Nguyen et al., 2019). Three key statements that the quality of support received from these support networks are captured under this pathway and are depicted in figure 4.3 above.

In responding to the statement SHG has SHG has "improved the quality of support I receive from people", a little above three-quarter (78%) approved it. For the next statement in

this band, which reads SHG has "improved the quality of care I receive from family members and/or caregivers", a little above three-quarter (77%) of respondents confirmed it. The other ways revealed from the open-ended question presents "I have received support from peers" as a related way under social support. This was identified by 4 (5.2%) respondents. Some of the expressions from participants include: "members attended my wedding ceremony and donated money to me" and "members visited me when I was sick and donated money to me". Also, 79 percent of respondents indicated that SHG has aided them to access economic resources such as money, fridges, and sewing machine.

4.4.1.4 Renewed sense of identity

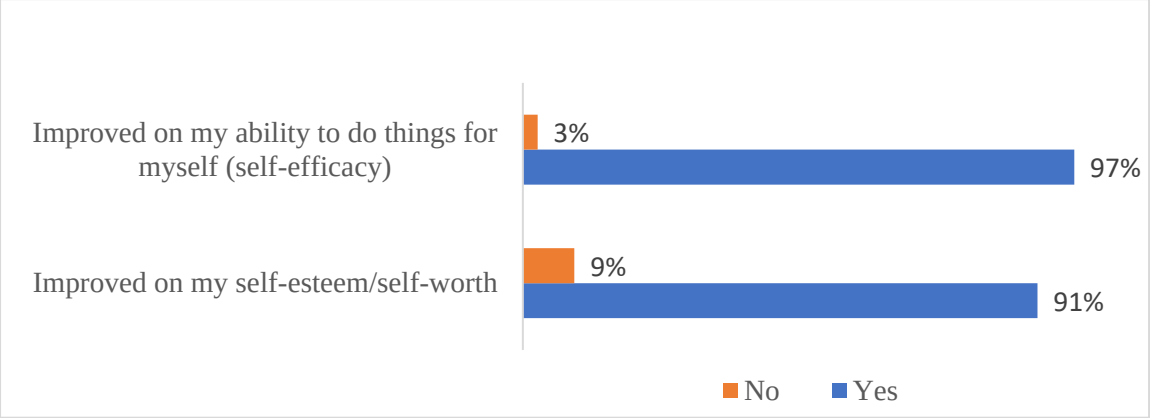

Figure 4.4. Response for two statements under renewed sense of identity (N = 77)

Two questions were asked to assess whether participation in SHG promotes better perception about oneself. An overwhelming majority (91%) of respondents confirmed that their participation in SHG has resulted in an improvement in their self-esteem/self-worth, and Only 9 percent have observed no difference in this respect. In reaction to the question, "… SHG has improved on my ability to do things for myself (self-efficacy)" greater majority (97%) of respondents confirmed they have this experience, with only few (3%) having no experience in this respect.

4.4.1.5 Improved ability to Cope with stigma

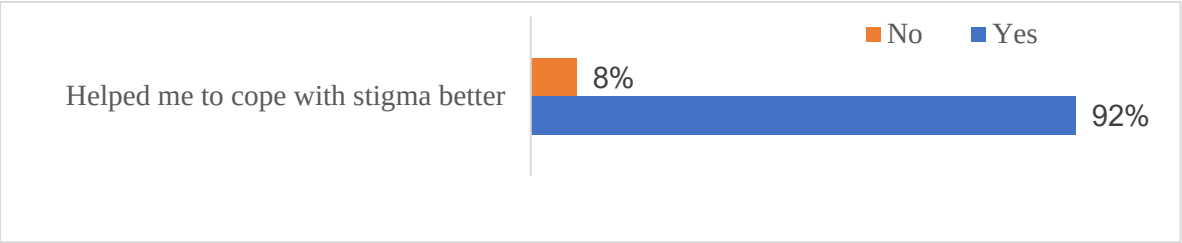

Figure 4.5. Distribution of participants on improved ability to cope with stigma

In my quest to explore whether SHGs equip members with coping skills to deal with stigma, I included one statement on stigma. Skills in coping with stigma is important in the journey towards recovery and social inclusion because this has implication for accessing mental health services. Greater majority of participants indicated that SHG has helped them to cope with stigma better.

4.4.2 Qualitative results

In partial achievement of the first objective of this study, in-depth interviews were conducted with three categories of SHG members namely volunteers, leaders, active members, and inactive members to explore the peculiar ways in which their participation in SHGs facilitate their recovery and social inclusion. One major theme with three subthemes emerged following a synthesis of the narratives from the participants. Figure 4.1 depicts the themes and subthemes that emerged from the thematic analysis.

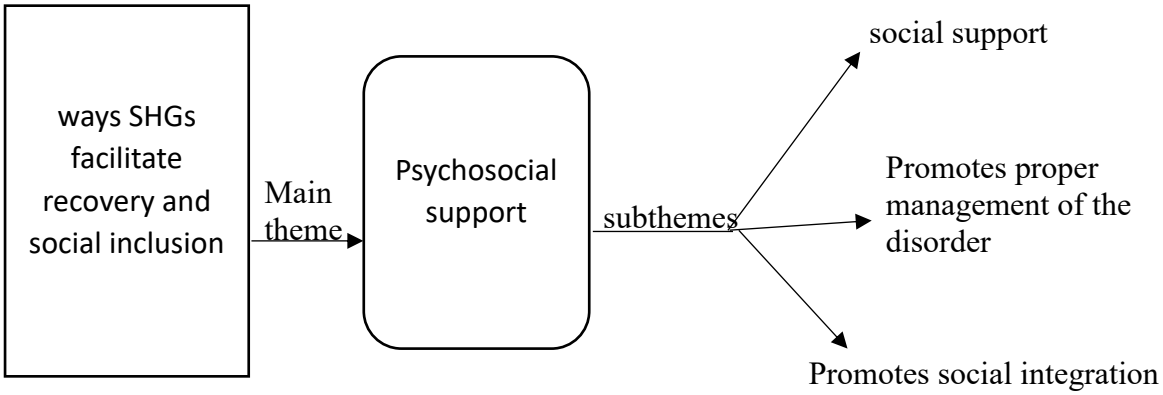

Figure 4.6 Themes and subthemes on ways in which SHGs facilitate recovery and social inclusion of members

4.4.2.1 Psychosocial support

The role that SHGs play in the lives of participants is broadly described as provision of psychosocial support. This pathway to recovery and social inclusion plays out in three basic ways: 1) social support, 2) Promotes proper management of the disorder, and 3) Promotes social integration. These basic pathways form the subthemes of the main theme.

4.4.2.1.1 Social support

The group nature of Self-help groups provides a favorable context for members to develop a network of supportive individuals who have greater interest in promoting the mutual wellbeing of one another. Participants in the current study identified that SHGs facilitate their recovery journey and social inclusion through provision of instrumental, emotional, informational, and human rights supports. Details of the information under social support is presented under instrumental, emotional, informational, and human rights supports for the purpose of clarity.

Instrumental support

Participants identified that the groups provide financial support to members who express a need. Each of the groups confirmed that they keep either a bank account or have a treasurer who keeps their money. Their funds are primarily raised through payment of dues, and payment made by members who took interest free loans that were facilitated by the group. What this means is that some NGOs give interest free loans to some members and ask them to pay back the actual amount into the groups' purse so that it can be used to support other members. This form of support is mostly provided to members who express a need to buy medication, start a business or pay for transportation to visit the hospital. For instance, a group leader mentioned that: "there was a sister who used to bake bread but later she wanted to fry doughnut, so we withdrew GHc100 from the group's account and gave to her." Another group leader described how this plays out in her group:

> *Some of the members sometimes come to me and inform me that they did not get the medicine from the hospital. In that case, I help the person out by withdrawing money from the group's purse (if there is money) to buy the medicine for them.* (Niusha, Female).

Another way SHG members receive instrumental support is from the individual group members. some of the members support their peers with money to buy their medications or pay for cost of transportation to the hospital. Others provide peers with food, and gifts. For instance, one of the respondents stated that:

> *I live in the same house with a group member who has lost both parents. So, I have taken it upon myself to be his caregiver. I have been providing him with food* (Aliya, Member, Female).

Another respondent described how his group members provided him with free goods:

> *I recall one of my group members bought me a scratch card, even though it was Ghc 2. I went to buy biscuit from Adomaa and she refused to take the money. Sometimes I take pure water from Adomaa and her daughter without paying – it is not my intention not to pay but she chooses not to take the money because of the relationship we have as group members* (David, Former volunteer, Male).

Another way that SHGs members receive instrumental support is from external organizations. SHGs, by virtue of their recognition and easy identification by formal institutions (such as psychiatric hospitals/units, the District Assemblies, BasicNeeds-Ghana, MEHSOG, and other NGOs), stand at a vantage point to receive external support for its members. SHGs link their members to obtain livelihood support from external organizations by informing their members, helping them to apply and leaders submitting application forms to the relevant organizations. Some of the instrumental support mentioned are financial grants and interest-free loans; economic resources including deep freezers, knitting machines, sewing machines, and pop-corn machines; laptops; medications, and clothing. In addition, members receive travel allowances, and enjoy free meals when they attend programs organized by BasicNeeds-Ghana,

or any other organizations. One respondent numbered the tangible support she has received from external sources:

> *When I was an apprentice, I received a knitting machine from the group. Also, I received an amount of money from the group, and I used it to stock my store as you can see now. Recently, I received a deep freezer, but I am told we will pay in installment*. (Lukaya, Member, Female).

Niusha, a group leader elaborated on how individuals come to support the group members:

> *When people come to me and I take them to the members, they sometimes give them gifts. Some of the visitors also give me envelope containing money. The last envelope I received contained GHc 10.*

A participant also talked about the allowances he enjoys when he attends programs and how he saves money from them:

> *...In all these trips, I do not pay anything and because when you are travelling you take some risk, they give me risk allowances. And anytime we go for a program they give us money for transportation. And you know, when they give me the "T&T", if it is taxi/Uber I were to board, I go in for "Trotro" and keep what will be left on me.* (David, Former Volunteer, Male).

Emotional support

Another important support that members in SHGs provide to one another is emotional support. Provision of emotional support takes the form of visiting members when they are sick or bereaved. Also, when SHG members meet, it provides a conducive space for them to share their problems, empathize with one another, provide solutions to individual and common problems, and lough over some issues. The meeting contexts allow members to encourage one another and gain a sense of belonging. A group leader unveiled how the group provides emotional support to members when she iterated:

> *When some of us relapse or fall sick, we go to visit them and pray for them. We often do this after the meeting. For instance, I have been informed that one woman is sick, and we lost one of our members yesterday, so when we meet, we shall visit the woman and pray for her and also visit the family of the deceased to share our condolences.* (Niusha, Female).

A group member also pointed out how the SHG meetings helped her to realize her emotional needs:

> *When we meet to discuss and share our problems, it makes me feel happy and prevent me from thinking about a lot of things. And when we meet, I get encouraged because I realize that others have serious problems than mine.* (Lukaya-Aisha, Member, Female).

Another group leader described how she encourages her members during meetings:

> *I urge them to know that the disorders did not come once so they do not disappear once, it is a gradual process so we shall all get well. As I encourage them like that some people who might be weeping end up laughing* (Niusha, Leader, Female).

Informational support

Informational support emerged as a key type of psychosocial support that SHG members provide to one another. Informational support takes the form of disseminating information from formal organizations such as hospitals, BasicNeeds-Ghana, MEHSOG, and the District Assemblies to members. The dissemination of information is done primarily by leaders of the group upon receiving the information from any of the institutions mentioned. The content of such information includes dates and venues for outreach programs in the district (where free medications are provided to members), opening of applications for livelihood support, or distribution of livelihood supports. Borketey, a leader of a group described how members are kept informed:

> *As the leader of this group, when any information comes from MEHSOG or Ledzekuku Municipal Hospital, I am the one who receives it first and I pass it on to my members. If a program is to take place, I will be informed to organize my members to attend* (Male).

Khadija also provided evidence about how her group leader keeps her informed when she mentioned that: "she (the group leader) keeps me informed about dates that the leaders of the SHGs come to the hospital to give free medications to us and I go and take them for free." (Khadija, Member, Female).

Not only are SHG members informed about dates and venues for programs organized by formal organizations, but also the leaders note the review dates for members and remind them so that they do not run out of medicines. A leader described how she goes about this:

> *I visit members in their homes to remind them when the time to go for review is approaching. Every first Tuesday of the month, we go to Maamobi General Hospital for the medicine. So, I go round to tell them.* (Esther, Leader, Female).

Another form of informational support expressed by participants is learning from one another during meetings. As members share their views on issues such as stigma, how to adhere to treatment, and services available, it equips other members with in-depth knowledge about their condition and clear misconceptions they may have. For instance, Fatima, an inactive member said that:

> *When I was attending meetings, I got the opportunity to share what I know, and others also shared their experiences. From this, I learnt from others and others also learnt from me.*

Also, the leaders sometimes attend programs where they learn a lot about mental health issues and come back to teach the members during group meetings. One group leader unveiled this when she mentioned: "For programs that I attend alone, I come back to

teach my group members and other nearby groups about all I learnt." (Niusha, Leader, Female).

Human rights support

Promoting human rights of members emerged as a way of facilitating recovery and social inclusion of SHG members. Participants indicated that the leaders of SHGs stand in to provide evidence of mental disability and seek for bail members who find themselves in the grips of police. Aziz, a volunteer spoke about instances when he stood in to bail some group members:

> *Last year, Selina Tuffour (a SHG member) was selling at Katamanso and had a problem with three boys. Because of the nature of her disorder, she was able to beat them, broke into their shops and destroyed a lot of their products. … What happened was that they sent her to the Railway Police Station and locked her up. So, I followed up on her at the police station with all her documents. When I got there, I told the chief inspector that the lady that you have detained is a person with mental disability … The inspector kept quiet for a while and said take her away, and that was how it ended. … At Jamestown police station too, similar incident happened. That one, he was locked up for three days. When I heard about it, I took his records and spoke to the commander … and he was granted a bail.* (Okatakyie, Volunteer, Male).

Other members seek the support of group leaders to rebuke people who abuse them verbally in the community or report them to the police. Okatakyie, a volunteer narrated how he addressed the human right needs of such members:

The last time you visited me at the office, I told you one of our members came to tell me to help her report some people to the police because they have been disturbing her: anytime they meet her they call her "Obodamfo" (mad person). So, I told her I would talk to the people and that is exactly what I went to do.

4.4.2.2 Promotion of the proper management of the disorder

Personal recovery emphasizes living beyond the limitations posed by a neuropsychiatric disorder. This process is facilitated by putting the disorder under control through coping skills. Participants in this study brought to bear how their participation in SHG positions them to subdue the limitations posed by their disorders through coping mechanisms primarily related to adhering to biomedical treatment and increased knowledge about mental health issues.

With respect to adhering to biomedical treatment, participants noted that their participation in the group marked their first access to treatment in psychiatric hospitals as they were either not receiving any form of treatment or were using herbal and/or spiritual care. To others, their participation in SHGs facilitated access to prescribed medicines, and taking the medications on time as they are oriented about the importance of taking the medication in their recovery journey. One participant highlighted how her participation in the group was associated with accessing biomedical treatment:

> *When I joined the group, I began to go to the psychiatric unit at Maamobi Polyclinic for treatment. This was the first time I resorted to the use of biomedical treatment after many years of trying herbal medicine and spiritual healings. The medications and ancillary treatments were free, so I consistently took the medications and the symptoms of my condition subsided greatly. (Aliya, Member, Female).*

Niusha, a female group leader provided details about how the group helps peers to adhere to biomedical treatment:

> *Some of the members sometimes come to me to inform me that they did not get the medicine from the clinic. In that case, I help the person out by withdrawing money from the group's purse (if there is money) to buy the medicine for the person. … When we meet as a group, I ask them about how they are following their treatment plan. This*

opens the door for those with challenges in accessing their medication to tell us so we can help them to get the medicines. I also advise them to go for review to replenish their medications at least three days before the last dose is taken.

The leaders of the groups ensure that all the members take their medication as prescribed. In situations when a client refuses to take the medications, the leader attends to the person and ensures that he/she takes it. One leader explained how she goes about this:

Sometimes some of the clients refuse to take their medications. In such situations, I go to talk to them, and they obey me. There is one member who admire a white woman so much, so when I draw close to him, I tell him to take the medicine so that I make arrangement for him to marry a white woman, then he will take it. Meanwhile, if his brother tells him the same thing, he will not take it. We have built some rapport with them, so they respect us more than even their family members. (Niusha, Leader, Female).

In addition to adherence to biomedical treatment, participants emphasized that the observations made, and lessons learnt at group meetings, programs and workshops on mental health issues provide them with psychosocial support. The lessons offered by group leaders and some members help clear myths and misconceptions that members may hold about their disorders. This goes a long way to promote proper management of the disorder. The training programs organized by BasicNeeds-Ghana, MEHSOG, and the MHA on mental health issues that some members attend also equip them with problem solving and coping skills which help them to subdue the limitations posed by the disorder and help other members to do same. A participant related her narrative to this idea when she said:

The group offered us training on how to communicate and help people with mental illness or epilepsy. Those of us who started the group were lucky enough to attend

trainings and workshops at the Accra Psychiatric Hospital. We learnt about the signs that precedes the onset of severe mental disorders … as well as how to deal with any of these signs. (Aliya, Female).

4.4.2.3 Promotion of social integration among participants

Narratives from the participants underscored ways in which membership in SHG promotes participants' relationship with people in society and sense of belonging. Participants identified that SHGs offer them opportunity to assume leadership roles, attend meetings and programs, expand social network, renew their sense of identity, cope better with stigma, participate in community development projects and policy making, and develop relational and communication skills. Although all participants indicated that the group has helped them to integrate into society better, members who hold or had held leadership roles in the group, and those who have participated in the group for a longer time were forceful in testifying to this.

Participants talked about how the meetings organized by SHGs and other programs organized by BasicNeeds-Ghana, MEHSOG, and other organizations provide them with opportunity to come into contact with others, build new relationships, and explore new environments, an experience which they touted to facilitate social integration. A participant commented on how the group context take members out of state of isolation to connectedness with others:

…instead of you to stay in your room crying, thinking that you are the only person with mental illness, you come and meet a lot of people with diverse diagnosis. … Even though my condition is anxiety, I listen to people with Bipolar, schizophrenia, epilepsy, and others. (David, Former Volunteer, Male).

Others, especially the leaders, have had the opportunity to travel to different places within and outside of Ghana to attend programs. These multi-context experiences and exposure are of great value to them. One respondent revealed this in his narration:

> *Through this group I have travelled internationally: I have been to Cape Town for a summit just because I was interviewed like how you are interviewing me on phone from Cape Town. In this year, I travelled to Nairobi, Kenya.* (David, Former Volunteer, Male).

Other programs that participants have participated in include the Mental Health Day, elections, and National Sanitation Day. As members participate in these programs, it helps them to gain a sense of belongingness and enhance their acceptance by community members. A volunteer provided details about this:

> *When there is a program, they know us, so they write to invite our members to participate. Example is the clean-up exercise we do on every National Sanitation Day: we organize our members to participate in cleaning the gutters and the community and through that the people in the community get to know that oh they are also like us. … During the World Mental Health Day on every 10th October, we select some members to go to Ghana Broadcasting Corporation for a media program… Also, during general elections, the Ghana Federation of Disables and the Electoral Commission select some of the SHG members as election observers in their communities* (Okatakyie, Volunteer, Male).

As members participate in SHG activities and attend other programs, it makes them to be known by other organizations. Niusha, referred to this when she said:

> *Through this group, I got to meet Hon. Otiko Djaba who selected me to join her Foundation. … Also, through the group, people in the media got to know me and invite me to participate in programs on radios and televisions.* (Leader, Female).

Self-help group members get the opportunity to take part in some developmental issues in society. Participants reported that they took part in the drafting of policies and laws about mental health, participated in the advocacy for the implementation of the Mental Health Act, 2012 (Act 846). One participant explained how SHG members participated in the enactment and implementation of the Mental Health Act:

> *... In the drafting of the mental health bill, some of the SHG members were selected and took part. And, when we went to parliament to advocate for the implementation of the Mental Health Act, we organized some of the SHG members and went with them.* (Okatakyie, Volunteer, Male).

Participants pointed out how their participation in SHG has equipped them with opportunity to master leadership skills, learn how to relate well with others, and develop communication skills which aid them to engage variety of people competently. Participants noted the importance of mastering basic social skills such as avoiding conflict, doing away with begging, and building personal confidence to enable one to draw close to people and enable others to accept them. For instance, a participant commented on how her participation in SHG has equipped her with valuable social skills:

> *The group has helped me because I might have been tempted to beg for money from others, but when you do that people will notice you and will want to avoid you or even disrespect you. The group has helped me to dismiss thoughts of begging from my mind, so I do not beg. ... The group has put its hand on our hearts-we are advised to keep calm whenever others offend us.* (Akosua, Member, Female).

Another participant illuminated how she has mastered leadership skills and how that has exposed her to higher leadership positions:

> *The leadership of BasicNeeds-Ghana was pleased with my performance at the local level so when it came to a time to select 12 members to represent the groups at the*

> *national level, I was selected. In fact, that day I shed tears of joy because I never expected such an honor.* (Niusha, Leader, Female).

In terms of communication skills, some participants explained that through lessons gained from training programs, and practical application of these skills in helping peers, they are adept in communicating effectively with people with diverse mental health diagnosis as well as people at the workplace and other domains of life. She urged:

> *The group offered us training on how to communicate. As a result, I can communicate well with others, especially to people who have mental health problems. Someone suffering from mental disorders could isolate him/herself and would not talk to anyone. But I am able to draw close to such people and engage them in conversation to the dismay of people around. Now I am so skillful that I can talk to everyone who has epilepsy or mental illness effectively. (*Aliya, Member, Female).

Aliya further stated that her communication skills is also applied to resolve conflicts at her workplace, and she put it this way:

> *I am an Arabic teacher who teaches people with different age categories, and I can talk to all of them very well. Sometimes the parents come to complain that my child has done A, B, C. With such cases I first advice the parents not to discipline their children in public. I also call the child to advise him on the need to be obedient to the parents which work very well for them, and they come to thank me for the advice.*

Participants in SHGs also shared about how they are oriented to be resourceful, and supportive to others in society. Members are oriented to reach out to people and families battling with mental health problems, educate them, refer them to appropriate service centers or counsel them. This imbibes a new sense of patriotism in them and motivate them to make meaningful contribution community development by helping people in need of mental health services. One participant related to this idea when she said:

> *When I see that someone has a mental health problem, I draw close to the person to talk to him/her and help the person. … I remember there was a girl who lived in my neibourhood and was suffering from mental disorder. She was not talking to anyone: she was insulting people around her and was completely unfriendly. I drew close to her and asked her to calm down and talk to me, and she did. She narrated her story to me and after her narration, I cried. So, I told her father to take her to the psychiatric hospital and now she is feeling better. (Aliya, Member, Female).*

Another participant revealed how SHG members team up with community psychiatric nurses to do community education:

> *Sometimes we go to churches to talk about the disease. Some people keep their children or relatives suffering from the disease inside the house or room, meanwhile, there is treatment available. So, we go and talk to them to visit the clinic to collect some medication.* (Esther, Leader, Female).

Nadia, a female group member also pointed out how she ran to a volunteer of SHG for support when she first experienced the disorder and how she is motivated to reach out to others in similar situation to help. She said:

> *When my condition started, I went to tell Ante Marriam (the volunteer) about my problem, and she advised and assisted me to go to the psychiatric hospital for assessment and treatment. I began to take medication, and everything returned to normal after some time. Because of this experience, when I see someone suffering from similar condition, I tell the person to go to the hospital for medication or see Ante Marriam for help. I also use my own experience to encourage such people.* (Member, Female).

4.5 Comparison between the level of recovery for SHG members and non-SHG members

This section presents results for objective two of this study, which sought to compare the level of recovery for SHG members and non-SHG members. Results are presented for each of the five subscales of the short version of the recovery assessment scale and for the total item scale in a manner that enhances comparison. The chapter also presents results on hypothesis testing for hypotheses 1a and 1b. Table 5.1 presents results on the level of recovery for the intervention and control groups. The mean scores for each group on the scale and subscales are reported, the effect sizes of the differences observed between the groups are also reported, and the p values denoting the level of significance for the mean difference between the groups are reported.

4.5.1 Personal Confidence and Hope

The Personal Confidence and Hope subscale measured the extent to which participants believe in their own abilities to do things for themselves and perceive that good things will happen in their lives. The expression of self-confidence and hope is touted as a key indicator of personal recovery in mental health (Anthony, 1993). In Table 5.1 it is observed that SHG members had mean score (4.23) that is numerically higher than non-SHG members (4.01). An independent sample T-test was conducted to compare the mean scores of SHG and non-SHG members on the Personal Confidence and Hope subscale. SHG members ($M = 4.23$, $SD = .52$) compared to non-SHG members ($M = 4.01$, $SD = .60$) had significantly higher score, $t(160) = 2.54$, $p < .001$. The magnitude of the differences between the means was small ($d = .4$). This means that SHG members have significantly higher confidence and hope than non-SHG members, but this difference is small. This indicates that SHG, as an intervention makes a small positive impact on the personal confidence and hope of members.

Table 4.5

Scores of SHG and non-SHG members on RAS-24 and the subscales (N = 162. CI = .95.)

Scale/Subscales	SHG Members (M)	Non-SHG Members (M)	Effect size (d)	P value (2-tailed)
Personal Confidence and Hope	4.23	4.01	.4	<.05
Goals and Success Orientation	4.39	4.31	-	>.05
Willingness to ask for Help	4.03	3.93	-	>.05
Reliance on Others	4.09	3.89	-	>.05
No Domination by Symptoms	3.94	3.27	.7	<.001
Recovery Assessment Scale - 24	4.18	3.95	.5	<.005

M = mean. d = Cohen's d. CI = Confidence interval. P < .05 is significant. Mean scores range from 1-5, with lower scores indicating lower levels of recovery and higher scores indicating higher levels of recovery. d < .2 = $very\ small\ effect\ size$; $d \geq .2 < .5$ = small effect size; d ≥ 5 < .8 = $medium\ effect\ size$; $d \geq .8 =$ $large\ effect\ size$.

4.5.2 Goals and Success Orientation

The Goals and Success Orientation subscale assessed the extent to which the individual participants have a set of goals in life and the belief that the personal goals can be achieved. This subscale emphasizes the importance of renewal of mind from a state of meaningless and lack of focus in life to a state of meaningful existence characterized by having personal goals and believing that those goals can be achieved. These goals then serve as purpose for existence for the person experiencing neuropsychiatric disorders.

From Table 5.1, it is observed that SHG members had numerically higher mean score (4.39) than non-SHG members (4.31) on the Goals and Success Orientation subscale. An independent sample T-test was further conducted to compare the mean scores of SHG and non-

SHG members. There was no significant difference in the scores of SHG members (M = 4.39, SD = .66) and non-SHG members [M = 4.31, SD = .74; t(160) = .81, p >.05]. This means that there was no difference between the two groups in terms of having personal goals in life and believing that those goals can be achieved.

4.5.3 Willingness to ask for Help

The Willingness to ask for Help subscale measured positive help seeking behavior of the participants. This subscale spells out the importance of recognizing times that one genuinely needs other people's help and the willingness and ability to ask for such help in the recovery journey.

From Table 5.1 it is found that SHG members had a numerically higher mean score (4.03) than non SHG members (3.93). An independent sample T-test was further conducted to compare the mean scores of SHG and non-SHG members. There was no significant difference in the scores of SHG members (M = 4.03, SD = .85) and non-SHG members [M = 3.93, SD = 1.17; t(153) = .64, p >.05]. This means that there was no difference between the two groups in terms of having personal goals in life and believing that those goals can be achieved.

4.5.4 Reliance on Others

This subscale measured the availability and quality of social support of participants. The subscale echoes the importance of having network of people who are committed at helping participants especially in times of need. Table 5.1 provides that SHG members had a mean score (4.09) which is slightly higher than that of non-SHG members (3.89). An independent sample T-test was further conducted to compare the mean scores of SHG and non-SHG members. There was no significant difference in the scores of SHG members (M = 4.09, SD = .80) and non-SHG members [M = 3.89, SD = .91; t(160) = 1.50, p >.05]. This means that SHG members are not significantly different from non-SHG members in terms of social support.

4.5.5 No Domination by Symptoms

This subscale measured the extent to which participants cope better with the disorder and live a functional life even when symptoms of the disorder is present (i.e. live beyond the limitations of the disorder). This domain of recovery is loudly echoed in the definition of recovery as: a personal process and a way of life characterized by living a satisfying, hopeful and productive life even with the presence of psychiatric disabilities (Anthony, 1993).

From Table 5.1, it is presented that SHG members had a mean score (3.94) which is numerically higher than non-SHG members (3.27). An independent sample T-test was conducted to compare the mean scores the groups. SHG members (M = 3.94, SD = .81) compared to non-SHG members (M = 3.27, SD = 1.10) had significantly higher score, $t(160) = 2.54$, $p < .001$. The magnitude of the differences between the means was moderate (d = .7). This means that SHG members are significantly better able to live beyond the limitations of their disorders than non-SHG members. This also indicates that SHGs make moderate positive impact on the ability of members to live beyond the limitations posed by their disorders.

4.5.6 Recovery Assessment Scale – 24

RAS-24 measured recovery as a composite variable. This helps to provide a composite result. From Table 5.1, it is presented that the mean score of SHG members (4.18) was numerically higher than non-SHG members (3.95). An independent sample T-test was conducted to compare the mean scores of the groups. SHG members (M = 4.18, SD = .41) compared to non-SHG members (M = 3.95, SD = .55) had significantly higher score, $t(160) = 3.02$, $p < .005$. The magnitude of the differences between the means was moderate (d = .5). This means that SHG members have significantly better recovery outcome than non-SHG members. It also indicates that SHG, as an intervention, makes a moderate positive impact on the recovery of members.

4.5.7 Hypotheses testing on recovery

Two hypotheses namely 1a and 1b were stated to help achieve the objective two of this study. All inferences are drawn from table 4.3 to test the hypotheses.

4.5.7.1 Testing of hypothesis 1a

Hypothesis 1a sought to assess whether SHG intervention makes a real positive impact on the recovery outcomes of members. In other words, it sought to evaluate the effectiveness of SHG intervention in facilitating recovery for persons with neuropsychiatric disorders. The null and alternative forms of hypotheses were stated for hypothesis 1a. The null hypothesis stated that: "Persons with neuropsychiatric disorders who belong to SHGs are not likely to recover better than non-SHG members on RAS-24." And the alternative stated that: "Persons with neuropsychiatric disorders who belong to self-help groups are likely to recover better than non-SHG members on RAS-24."

In testing this hypothesis, an independent sample T-test was conducted to compare the mean scores of SHG and non-SHG members on the RAS-24. SHG members (M = 3.94, SD = .81) had significantly higher level of recovery than non-SHG members [M = 3.27, SD = 1.10; $t(160) = 2.54$, $p < .001$]. Based on this finding, the null hypothesis is rejected and the alternative hypothesis which states that "Persons with neuropsychiatric disorders who belong to self-help groups are likely to recover better than non-SHG members on RAS-24" is accepted. This finding affirms that SHG intervention is effective in facilitating recovery for persons with neuropsychiatric disorders in the Greater Accra Region of Ghana.

4.5.7.2 Testing of hypothesis 1b

Hypothesis 1b sought to evaluate the effectiveness of SHGs in facilitating any of the five domains of recovery as measured by the five subscales of recovery namely Personal

Confidence and Hope, Willingness to Ask for Help, Goal and Success Orientation, Reliance on Others, and No Domination by Symptoms. In view of this, the null hypothesis stated that: "Persons with neuropsychiatric disorders who belong to SHGs are not likely to recover better than non-SHG members, on all the five subscales of recovery." And the alternative hypothesis stated that: "Persons with neuropsychiatric disorders who belong to SHGs are likely to recover better than non-SHG members, on at least one of the five subscales of recovery."

An independent sample T-test was conducted to compare the mean scores of SHG and non-SHG members on each of the five subscales of recovery. SHG members (M = 4.23, SD = .52) had significantly higher score than non-SHG members (M = 4.01, SD = .60) on the Personal Confidence and Hope subscale, $t(160) = 2.54$, $p < .001$. Also, SHG members (M = 3.94, SD = .81) had significantly higher score than non-SHG members (M = 3.27, SD = 1.10) on the No Domination by Symptoms subscale, $t(160) = 2.54$, $p < .001$. However, there was no significant difference in the mean scores of the groups on three subscales of recovery namely Goals and Success Orientation [$t(160) = .806$, $p > .05$], Willingness to Ask for Help [$t(153) = .64$, $p > .05$], and Reliance on Others [$t(160) = 1.513$, $p > .05$].

The results tell that SHG is independently effective in facilitating recovery in two key domains: 1) promoting self-confidence and hope (personal confidence and hope) and enabling members to live beyond the limitations posed by the disorders (no domination by symptoms). Based on this finding, the null hypothesis is rejected and the alternative hypothesis which states that: "Persons with neuropsychiatric disorders who belong to self-help groups are likely to recover better than non-SHG members on at least one of the five subscales of recovery" is accepted.

4.6 Comparison between level of social inclusion for SHG members and non-SHG members

This section presents results for the objective three of this study. The objective three sought to compare the level of social inclusion for SHG members and non-SHG members. This

is intended to contribute to achieving the study's aim of assessing the effectiveness of SHGs in facilitating recovery and social inclusion. Table 4.6 presents results for the level of social inclusion for the intervention (SHG) and control groups (non-SHG). The mean scores for each group on the scale and subscales are reported, the effect size, and the p values denoting the level of significance for the mean difference between the groups are reported.

Table 4.6

scores of SHG and non-SHG members on SIS and the subscales

Scale/subscale	SHG Members (n = 77)	Non-SHG members (n = 85)	Effect size (d)	P value (2-tailed)
Social Isolation	3.31	2.88	.6	<.001
Social Relations	3.12	2.88	.4	<.01
Social Acceptance	3.40	3.05	.6	<.001
Social Inclusion Measure	3.12	2.92	.5	<.005

Mean scores range from 1-4 with lower scores indicating lower level of social inclusion and higher scores indicating higher level of social inclusion. CI = Confidence interval. P < .05 is significant. d means Cohen's d. d < .2 = very small; $d \geq .2 < .5$ = small effect size; d ≥ 5 < .8 = $medium\ effect\ size$; $d \geq .8 = large\ effect\ size$.

4.6.1 Social Isolation

The SI subscale measured the extent to which participants perceive to have moved from a state of loneliness and inactivity (isolation) to a state of connectedness and meaningful participation in social activities. Items such as "I have friends I see or talk to every week" and "I have felt that I am playing a useful part in society" come under this subscale. From Table 4.3, is observed that the mean score of SHG members (3.31) was numerically higher than non-SHG members (2.88). An independent-sample T-test was further conducted to compare the mean scores of SHG and non-SHG members on the SI subscale. SHG members (M = 3.31, SD = .66) compared to non-SHG members (M = 2.88, SD = .81) had significantly higher score, t(160) = 3.72, P <.001. The magnitude of the difference between the mean scores of the groups was moderate (d = .6). This means that SHG members are moderately better connected with

others and engage in social activities than non-SHG members. This indicates that SHG, as an intervention makes moderate positive impact on the ability of members to connect with others and participate in social activities.

4.6.2 Social Relations

The SR subscale measured the extent to which participants interact with others and perform roles that have real benefits to others. Some of the items in this subscale is: "I have been involved in a group, club, or organization that is not just for people who use mental health services". From Table 4.3, is observed that the mean score of SHG members (3.12) was numerically higher than non-SHG members (2.88). An independent-sample T-test was further conducted to compare the mean scores of SHG and non-SHG members on the SR subscale. It was found that the score of SHG members (M = 3.12, SD = .58) compared with non-SHG members (M = 2.88, SD = .58) was significantly higher, $t(158) = 2.64$, $p < .01$. The magnitude of the differences between the mean scores of the groups was small (d = .4). This means that SHG members have better social relations than non-SHG members, but this is a small difference. This indicates that SHG, as an intervention, makes a small positive impact on the social relations of members.

4.6.3 Social Acceptance

The SA subscale measured how participants perceived to be tolerated (accepted) by others. Some of the items on this subscale are: "I have felt accepted by my neighbours" and "I have felt free to express my beliefs (for example political or religious beliefs). An independent sample T-test was conducted to compare the scores of SHG and non-SHG members on the SA subscale, and Table 4.3 contains the results. SHG members (M = 3.40, SD = .53) compared to non-SHG members (M = 3.05, SD = .58) had higher mean score $t(160) = 3.98$, $p < .001$. The extent of the differences in the mean scores of the groups was moderate (d = .6). This means

that SHG members moderately feel accepted by other people than non-SHG members. This indicates that SHG, as an intervention makes moderate positive impact on members by making them feel accepted by others in society.

4.6.4 Social Inclusion

The SIS, as a composite scale measured the level of social inclusion for participants. As a composite scale, it reflects the social inclusion of participants within the context of three factors namely SI, SR, and SA. From Table 4.3 it is found that SHG members had a mean score (3.12) which is numerically higher than non-SHG members (2.92). An independent sample T-test was further conducted to compare the scores of SHG and non-SHG members on the SA subscale. SHG members (M = 3.12, SD = .55) compared to non-SHG members (M = 2.92, SD = .54) had higher mean score, $t(158) = 3.46$, $p < .001$. The magnitude of the difference in the mean scores of the groups was moderate (d = .5). This means that SHG members are moderately better included in society than non-SHG members. This further indicates that SHG, as an intervention, makes a moderate positive impact on the social inclusion of members.

4.6.5 Hypotheses testing on social inclusion

Hypotheses 2a and 2b were stated to help assess the effectiveness of SHGs in facilitating social inclusion for persons with neuropsychiatric disorders. These hypotheses invariably contribute to achieving the objective three of this study.

4.6.5.1 Testing of hypothesis 2a

Hypothesis 2a sought to assess whether SHG is effective in facilitating social inclusion of members. The null hypothesis stated that: "Persons with neuropsychiatric disorders who belong to SHGs are not likely included in society better than non-SHG members on SIS" and the alternative hypothesis stated that: "Persons with neuropsychiatric disorders who belong to SHGs are likely to be included in society better than non-SHG members on SIS."

An independent sample T-test was conducted to compare the mean scores of SHG and non-SHG members on the SIS. SHG members (M = 3.12, SD = .55) had significantly higher score than non-SHG members [M = 2.92, SD = .54; t(158) = 3.46, p <.001]. This result indicates that SHG makes a significant positive impact on the social inclusion of members. The null hypothesis is therefore rejected and the alternative which states that: "Persons with neuropsychiatric disorders who belong to SHGs are likely to be included in society better than non-SHG members on SIS" is accepted.

4.6.5.2 Testing of hypothesis 2b

Hypothesis 2b sought to evaluate the effectiveness of SHGs in facilitating any of the three domains of social inclusion which are measured with three subscales namely Social Isolation, Social Relations, and Social Acceptance. The null hypothesis was that: "Persons with neuropsychiatric disorders who belong to SHGs are not likely included in society better than non-SHG members, on all the three subscales of social inclusion" and the alternative hypothesis was that: "Persons with neuropsychiatric disorders who belong to self-help groups are likely to be included in society better than non-SHG members, on at least one of the three subscales of social inclusion."

An independent sample T-test was conducted to compare the mean scores of SHG and non-SHG members on each of the three subscales of social inclusion. On the Social Isolation

subscale, SHG members (M = 3.31, SD = .66) had significantly higher score than non-SHG [M = 2.88, SD = .81; t(160) = 3.72, P <.001]. Similarly, on the Social Relations subscale, SHG members (M = 3.12, SD = .58) had significantly higher score than non-SHG [M = 2.88, SD = .58; t(158) = 2.64, p <.01]. In much the same way, on the Social Acceptance subscale, SHG members (M = 3.40, SD = .53) had significantly higher score than non-SHG members [M = 3.05, SD = .58; t(160) = 3.98, p <.001]. These results indicate that SHG members significantly facilitate social inclusion in all the three domains specified. Based on these results, the null hypothesis is rejected and the alternative which states that: "Persons with neuropsychiatric disorders who belong to self-help groups are likely to be included in society better than non-SHG members, on at least one of the three subscales of social inclusion" is accepted.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

This chapter is dedicated for the discussion of the findings presented in chapter four. Findings for each objective is discussed in tune with contextual issues, empirical literature, and theory.

5.2 Socio-demographic characteristics of participants

Participants in SHGs and non-SHGs were similar on some key socio-demographic variables comprising sex, education, religion, employment status, and diagnosis. This implies that these socio-demographic variables did not serve as confounding variables to the current study. However, SHG members were significantly older than non-SHG members, and more non-SHG members were married or had married before in their lives compared to SHG members. Consistent with prior studies (e.g., Slade & Longden, 2015) the differences in age and marital status were found to have no effect on measures of recovery and social inclusion. These findings indicate that the two groups were comparable on demographic and diagnostic backgrounds. In addition, all participants had been on biomedical treatment for at least 1 year and were on medication at the time of data collection.

5.3 Ways in which participation in self-help groups facilitate recovery and social inclusion

Under the quantitative study, it was found that SHGs facilitate recovery and social inclusion of members in five dimensions namely (1) promotion of the proper management of the disorder; (2) promotion of social integration among participants; (3) Social support; (4) renewed sense of identity; and (5) improved ability to cope with stigma. This is an indication that SHGs support their members in multiple domains of life, and this is a good premise for facilitating multidimensional outcomes such as recovery and social inclusion. The qualitative

study also converged on the fact that SHGs support members in multiple domains of their lives by emphasizing that it provides psychosocial support to members. This observation is not a unique characteristic of SHGs in this study alone as other studies (e.g. Cohen et al., 2012; Ochocka et al., 2006) have reported that SHGs support their members in multiple ways.

A reflection on the findings from the current study projects SHGs as an important informal support in the lives of persons with neuropsychiatric disorders. The study established that peers support one another to access, take and adhere to treatment plan. The follow-up from group leaders, the culture of reminding members about review dates and intervening in situations where members refuse to take their medications are pivot to members' betterment of managing their disorders. This finding is not new as other studies have established that participation in SHG leads to consistent use of biomedical treatment (Cohen et al., 2012; Magura et al., 2002; Sakyi, 2015).

The study found that members in SHGs master interpersonal and communication skills, attend programs organized by NGOs or the nation, get the opportunity to meet people, take part in national decisions and policies, and gain confidence to relate with people in their communities and these consequently make them able to integrate into society better. These findings are in line with the empowerment theory which proposes that informal groups like SHG creates a conducive environment where members learn and master social skills and apply these skills in other domains of their lives (Zimmerman, 2000; Zimmerman, & Warschausky,1998). As SHG members master interpersonal and communication skills, and develop confidence, they tend to exert control over their environment by participating in decisions and policies that have direct bearing on their lives. This explains why some SHG members in Ghana participated in the committee that drafted the Mental Health Bill which was passed into law as the Mental Health Act, 2012 (Act, 846).

The study confirmed the findings from existing studies (e.g Cohen et al., 2012; Mead et al., 2001; Nelson et al., 2006) that participation in SHG is associated with social support and social network. This is not strange because the leaders of the groups tend to become one of the most reliable people in the lives of SHG members and in most instances, peers tend to become friends to one another, thereby increasing the social network size of members. Also, as members get the opportunity to travel, attend programs within and outside their communities, they meet new people and make friends with some. This simple opportunity presented to members in SHGs move them from a state of isolation to a state where they become connected to people within and outside their communities.

It is important to note that SHGs are known to organizations, government institutions, and other social groups who invite them to participate in their activities. This is evidence in SHGs members being invited by the Electoral Commission of Ghana to serve as election observers as well as by Parliament of Ghana to participate in the drafting of the Mental Health Bill, which was passed into law in 2012. This finding from the study corroborates the community level of analysis of the empowerment theory, which emphasizes that engagement among institutions in a community create opportunity for people to participate actively in social activities and ultimately get integrated into society. Thus, as SHG members engage with relevant institutions and are invited to participate in various activities, it provides opportunities for group members to be integrated into society. In addition, SHG members tend to provide tangible, emotional, and informational support to themselves and that they become aware of the support systems around them. This enables them to access tangible support from formal organizations including BasicNeeds-Ghana, MEHSOG, and the DACF for PWDs. These support which come in the form of financial and material capital, job training, and entrepreneurial skills enable some of them to engage in economic activities, take charge of

their lives and live beyond the limitations posed by the disability. This is important because most of the SHG members experience financial constraints.

Another finding from this study is that participation in SHG leads to renewed sense of identity. Members gain a new sense of identity as they participate in the activities of SHGs, and this new identity influence how they live their lives. The lessons learnt from group meetings, sharing of experiences among peers, encouragement from others, appreciations, promotions, and awards from formal organizations are just few of how members gain positive self-esteem and self-efficacy from the group. This finding is in congruence with the study by Markowitz (2015) who also found that active involvement in SHGs was significantly associated with high self-esteem. Additionally, SHG members tend to look beyond themselves and engage in a new role as good citizens in their communities where they tend to reach out to other people with similar problems and help them to regain autonomy over their lives. In line with this, some gained new commendatory names such as “doctor” and “nurse”. This finding is grounded in the community level of analysis of the empowerment theory. The finding highlights that SHG members are being accepted by members of the community as they reach out to them to offer psychosocial support to people who need it. The openness of community members to the services provided SHG members, and their appreciation of the services substantiates the fact that the community members provide opportunity for SHG members to relate with them.

The finding that SHG promotes human rights emerged as a novel pathway. Volunteers and leaders of the groups stand by their members and fight for them to be freed when they find themselves in the police custody. This novel finding is well grounded in the empowerment theory. One key proposition of the empowerment theory is that empowerment process seeks to provide opportunity for individuals, organizations, and communities to gain autonomy, access resources, and become critically aware of their socio-political contexts (Zimmerman, 1995). In

this case, volunteers, and leaders of SHGs act upon their awareness of the laws of the community and use them as a strength to advance the human right needs of their members when they are being abused. Leadership is therefore a key empowering role that exist in the SHGs. This offer opportunity for some of the members to master some peculiar skills that are used to foster the mutual interest of other members.

The services provided by SHGs is seen to support primary mental health system and contribute to promoting access to biomedical treatment. This is linked to the fact that SHG members are equipped with requisite expertise and are motivated to reach out to non-SHG members to offer peer support and recommend the use of primary mental health services. Meanwhile, this assertion is novel and more empirical studies could help to clarify it. More so, the finding that SHG members are recognized as resourceful mental health service providers in their communities such that members in the community go to them for mental health support appears to be a novelty, as the literature is silent on this.

5.4 Level of recovery for Self-help group members and non-Self-help group members

The objective two of this study sought to compare the level of recovery of SHG and non-SHG members. This was done so that a conclusion could be drawn on the effectiveness of SHG on the recovery of members. Consistent with the empowerment theory, this study found that SHG members were significantly recovered better than non-SHG members ($p<0.01$). This finding exhibits that SHGs provide enabling environment and support for members which make them better off than their counterparts who do not participate in their activities. As noted in the qualitative findings, members in SHGs receive psychosocial support which is critical resource in their recovery journey. The informal context that governs SHG meetings also serve as a catalyst for members to share their personal stories and seek assistance from others, and these are rich opportunities that empower members to advance in their recovery journey. This is in synch with the proposition of the empowerment theory which emphasizes that

organizations that provide informal contexts for engagement are adept in facilitating empowerment outcome.

The finding that SHG members are better recovered than non-SHG members is consistent with empirical studies that found that participation in SHG is associated with better recovery for mental health service users (Fukui et al., 2010; Lloyd-Evans et al., 2014; Segal et al., 2010). However, this finding is not in agreement with studies that are skeptical in accepting that SHGs make significant impact on the recovery of members (Markowitz, 2015; Pistrang et al., 2008). Apart from the fact that the research designs used in the existing literature (one used longitudinal design and the other used systematic review) differ from the one used in this study, the difference in the structure, membership composition and focus of the SHGs studied in each of the primary studies could be responsible for the discrepancies observed in the findings.

It was found that SHGs were independently effective in promoting self-confidence and hope of members ($p<0.05$) and enabling members to live beyond the limitations posed by their disorders ($p<0.001$). This finding is not so surprising because the qualitative study emphasized that SHG meetings provide conducive context for members to encourage one another, and this culture has great prospect in improving the self-confidence and hope of members. It was further stressed by the qualitative findings that SHG members are supported in several ways to adhere to biomedical treatment and obtain personal and social skills to cope well with the disorder. As members master these skills over time, they become resilient and hence become adept in subduing the limitations posed by their disorders. Moreover, the primary aim of SHGs is to support members to cope well with their disorders and live fruitful lives, and this tend to strengthen efforts of members to overcome the impediments placed on their functioning by the disorders.

It was found that the magnitude of the impact that SHGs make on the recovery of members was moderate. This trend of effect size was reported by Lloyd-Evans et al. (2014)

who stated that SHGs make small to moderate positive impact on the recovery of members. This is an indication that SHG is one of the ways that facilitate recovery but not the only way as it has been emphasized by Deegan (1988).

5.5 Level of social inclusion for Self-help group members and non-Self-help group members

The objective two of this study sought to assess the effectiveness of SHGs by comparing the level of social inclusion for SHG participants and non-SHG participants. It was found that members in SHGs are included in society better than non-SHG members ($p<0.01$). Also, members in SHGs had significantly higher scores on all the three subscales of social inclusion, namely Social Isolation, Social Relations, and Social Acceptance. Thus, SHG members were more socially connected ($p<0.001$), have healthy social relationships ($p<0.01$), and were more accepted by others in society ($p<0.001$). These findings are not surprising when situated within the prism of the empowerment theory, which emphasizes that organizations that provide favorable contexts for engagement and participation in relevant activities are able to stimulate members to achieve their individual goals. Relating this to the constructs of interest, SHGs are able to create a healthy network of persons with neuropsychiatric disorders which provide them with the opportunity to relate with one another, strengthen their ability to engage with members in society, and link members up to participate in major social activities.

The current findings provide a premise to emphasize that SHGs in Greater Accra Region of Ghana are effective in facilitating the inclusion of persons with neuropsychiatric disorders into society. This projects SHG as an important social support that can be used to fast-track effort of mental health institutions in promoting the social integration of service users. For instance, lessons from the qualitative findings denote that SHG members get the opportunity to participate in national programs, take part in policy development, embark on community educations, reach out to people with similar needs in the communities to support, and that they reported better management of the disorder which enhances their acceptance by community members, and consequently promote their inclusion in society.

These findings from this study are not novel- they corroborate many studies (e.g. Cohen et al., 2012; Forchuk et al., 2005; Mead et al., 2001; Ochocka et al., 2006; Sakyi 2015; Yanos et al., 2001) that have also found that SHG members have better social skills, formidable social network, and are better able to integrate into society than non-SHG members. These findings, however, contradict a longitudinal study by Nelson et al. (2006) which found that both active and inactive participants in peer support groups had reduced social integration at 18-months follow-up. The dissonance in the findings can be greatly attributed contextual factors in the SHGs because in the study by Nelson and colleagues, both the experimental group (active members) and the comparison group (inactive members) recorded a reduction in score on the social integration scale. It could be that an unusual event took place which adversely affected participants in both groups. It can also be inferred that the momentum with which the SHGs were supporting the members reduced over time.

It was found that SHGs make small to moderate positive impact on the social inclusion of members. This indicates that SHGs alone may not make a large impact on the social inclusion of members. This inference supports the idea shared by some authors that SHGs should not be used in isolation of other mental health services including biomedical treatment and care from family members (Lloyd-Evans et al., 2014; Nguyen, Holton, Tran, & Fisher, 2019). Thus, SHGs are better understood as a key support system among other systems of support that facilitate the social inclusion of persons with neuropsychiatric disorders. Another implication from this finding is that if SHGs are supported well, they can make even greater impact on the social inclusion of members than what is observed in this study. This indicates that leadership of SHGs should work to strengthen the capacity of the groups to yield greater results in the lives of members.

CHAPTER SIX

SUMMARY OF KEY FINDINGS, CONCLUSION, AND RECOMMENDATIONS

6.1 Introduction

This chapter provides the summary of the key findings of the study, the conclusions and the recommendations as informed by the findings and the discussion.

6.2 Summary of key findings

The summary of findings is presented in line with the objectives of the study.

6.2.1 Ways in which participation in self-help groups facilitate recovery and social inclusion

The objective one of this study sought to explore the ways in self-help groups facilitate recovery and social inclusion of members who live with neuropsychiatric disorders in the Greater Accra Region of Ghana. This was approached with both a quantitative and qualitative methods. Through 13 dichotomous statements that were presented to participants and an open-ended question, the quantitative study found five pathways in which SHGs facilitate recovery and social inclusion. They are (1) promotes proper management of the disorder; (2) promotes social integration; (3) social support; (4) renewed sense of identity; and (5) improved ability to cope with stigma. The qualitative study converged on the pathways identified in the quantitative study and provided further details about the mechanisms through which they play out in real life. Specifically, the SHGs were found to provide social support to members, encourage, advice and support members to access biomedical treatment and cope well with their disorders, and equip members with the necessary social and communication skills, and the orientation to integrate into society better. These findings are consistent with existing studies that found that SHG promote social inclusion in multiple domains of life (Cohen et al., 2012; Magura et al., 2002; Ochocka et al., 2006; Sakyi, 2015).

In terms of novel findings, this study found that SHGs promote human rights of members by following up on members who find themselves in police custody to get them freed. Also, some SHG members are recognized as mental health service providers by community members and hence people tend to come to them when they have mental health problems for support. These findings are grounded in the empowerment theory that SHG provides favorable context for members to share their problems and brainstorm solution, learn social skills that are transferable across life domains, and become critically aware of the resources in the socio-political environment and access them.

6.2.2 Level of recovery for Self-help group members and non-Self-help group members

The objective two sought to evaluate the effectiveness of SHGs by comparing the level of recovery for SHG members and non-SHG members on a measure of recovery. SHG members were found to be more likely than non-SHG members to recover and that SHG, as an intervention, makes a moderate positive impact on the recovery of members. In terms of the five dimensions of recovery measured, SHG members were found to be more likely than non SHG members to have better self-confidence and hope (Personal Confidence and Hope) and live beyond the limitations posed by their disorders (No domination by Symptoms). However, SHG members were found to be no different from non-SHG members on measures of Goals and Success Orientation, social support (Reliance on Others), and positive help seeking behavior (Willingness to Ask for Help).

These findings are in synch with studies that found that SHGs make significant positive impact on recovery of members (Fukui et al., 2010; Lloyd-Evans et al., 2014; Segal et al., 2010), and conflicts with studies that reported mixed results on the impact of SHGs on recovery. The findings of this study fulfil the prediction of the empowerment theory that SHG, as informal organization is adept in facilitating recovery of members.

6.2.3 Level of social inclusion for Self-help group members and non-Self-help group members

The third objective sought to evaluate the effectiveness of SHGs in facilitating social inclusion by comparing the level of social inclusion of SHG members and non-SHG members. SHG members were found to be more likely than non-SHG members to be included in society and that SHG, as an intervention makes a moderate positive impact on the ability of members to be included in society. Also, SHG members were more likely than non-SHG members to have healthy social relationships**,** be socially connected, and be accepted by others in society.

These findings corroborate studies (e.g. Cohen et al., 2012; Forchuk et al., 2005; Mead et al., 2001; Ochocka et al., 2006; Sakyi 2015; Yanos et al., 2001) that found that SHG members are included in society better, and contradict a study by Nelson et al. (2006) who found that participation in SHG was associated with reduced social integration. These findings find a fit with the empowerment theory which predicted that SHG, as an informal organization is adept in facilitating social inclusion of members.

6.3 Recommendations

In line with the findings from this study and the discussion, recommendations are made for policy and practice, and future research. Implication for social workers are also discussed.

6.3.1 Policy and practice

Volunteers and leaders of SHGs should be targeted and appointed by MHA to serve as mental health peer providers at the community level. This could help strengthen the community mental health system in Ghana as these peer providers will be more capable to follow up on clients in their communities and link them to appropriate mental health resources available. This policy initiative has greater prospect in reducing the huge mental health gap we have in Ghana.

The Mental Health Authority, mental health NGOs, and community leaders are encouraged to promote the establishment of SHGs as a vehicle for facilitating recovery and social inclusion of service users in urban areas, especially in Greater Accra Region. This will provide access to many others who need the kind of psychosocial support provided in SHG context to get it. SHGs that are yet to be established should be structured to possess the key features of being informal and include both caregivers and service users. For the existing SHG members, the MHA and NGOs in mental health should organize more capacity building and knowledge mobilization programs for the members.

The MHA, NGOs, and administrators of the DACF for PWDs should provide financial support to SHGs to strengthen their capacities to function. This initiative is provided on the premise that SHGs should be viewed as an important organization in the lives of persons with neuropsychiatric disorders in their recovery and social inclusion journey. In addition, the leadership of SHGs should reach out to individuals and corporate organizations within their local context to sponsor their activities. This could go a long way to strengthen their ability to embark on all activities they would like to undertake to build the capacity of members.

Frontline mental health professionals are encouraged to inform clients about the psychosocial benefits of SHGs that are identified in this study and encourage them to join or form some. Also, persons with neuropsychiatric disorders who need psychosocial support are encouraged to join SHGs.

6.3.2 Direction for future research

Future studies should replicate this study on rural population to provide a balanced understanding of the contributions of SHGs in Ghana.

Future studies should adopt the longitudinal design to observe the impact of SHGs on participants over time in Ghana.

Future studies should examine the association of socio-demographic variables such as religiosity on recovery and social inclusion to provide complete understanding on the determinants of recovery and social inclusion of persons with neuropsychiatric disorders in Ghana.

Future studies should assess the impact of SHGs on suicide to ferret out the unintended roles that SHGs could play in addressing this important mental health issue.

Future studies should also examine the usefulness of SHGs to caregivers.

6.3.3 Implication for social work practice

Social work is a helping profession. As a result, social workers pay particular attention to the vulnerable, including minority groups, children, the elderly, women, prisoners, and persons with mental health problems. The profession of social work entreats social workers to view clients as key actors in the process of solving individual and social problems. Social work takes the strength perspective to elaborate the fact that, not only are clients' key actors in the helping process, but they are also masters of their own problems (Rogers, 2010). In view of this social interventions that place clients at the center are favored by the social work profession. By using the empowerment theory as a lens, this study has found that SHGs for persons with neuropsychiatric disorders are adept in facilitating recovery and social inclusion. Considering this, social workers in the field of mental health should incorporate SHG into their operational framework to advance empowerment outcomes in the service users in which field? E.g. district social workers in Accra; Also, Social workers involved in policy development should recognize the need to strengthen and support informal groups to become a vehicle for achieving outcomes in their areas of operation.

6.4 Conclusion

Persons living with neuropsychiatric disorders are reported to face social barriers and live less fruitful life compared to the average population. Recovery and social inclusion for persons with neuropsychiatric disorders are stressed by practitioners and researchers and social support systems are sensed to be important partner in promoting this focus. Mental health SHG is one of the informal support systems that has been debated in literature to promote recovery and social inclusion for mental health service users. This study examined the contributions and effectiveness of SHGs in facilitating recovery and social inclusion for persons with neuropsychiatric disorders in the Greater Accra Region of Ghana.

SHGs in Greater Accra Region were found to facilitate the recovery and social inclusion of members through the provision of psychosocial support. The groups appear to make moderate positive impact on the recovery and social inclusion of members. This indicates that SHG for mental health service users is a key complement to other services in promoting recovery and social inclusion. Stakeholders in mental health are strongly encouraged to establish and support SHGs to become a key partner in promoting recovery and social inclusion for persons with neuropsychiatric disorders.

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APPENDICES

Appendix 1: Questionnaire for self-help group members

University of Ghana

College of humanities

School of social Sciences

Department of Social Work

This questionnaire seeks to solicit responses from you as a means to gathering data on the study the topic "**the role of mental health self-help groups in the recovery and social inclusion of persons with mental disorders."**

INSTRUCTION: Please answer all questions in this questionnaire.

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

TODAY'S DATE **……**

1. Sex? Male ☐ Female ☐

2. Age ……

3. Highest level of education?

None ☐ Primary ☐ Junior High School ☐

Senior High School ☐ Tertiary ☐

4. Religion

Christian ☐ Muslim ☐ Traditionalist ☐

others (please specify) …….

5. What is your current marital status?

Single ☐ Separated ☐ Married☐ Divorced☐ Widowed ☐

6. In which year were you diagnosed with mental health problem?

……

7. How long have you been on psychiatric treatment for your mental health problem?

……

8. What is your current employment status?

Employed ☐ Self Employed ☐ Unemployed ☐

9. What is the name of the self-help group you belong to?

……

10. How long have you been a member of the self-help group? ……

11. Name of hospital where you access mental health service

……

12. How involving have you been in the self-help group for the past 6 months? I have attended …… in meetings and activities organized by the group.

less than half ☐ about half ☐ more than half but not all ☐

All ☐

13. Since the onset of your mental health problem, which of the categories of people below have been helpful to you (select all that apply to you)?

Neighbours ☐ Friends ☐ Family members (both nuclear and extended) ☐

Members of my Religious group ☐ Self-help group members ☐

Others:……

11. How will you evaluate the quality of support provided to you by the category of people listed in the table below, since the onset of your mental health problem?

	Extremely poor	**poor**	**Normal**	**Good**	**Excellent**
Neighbours					
Friends					
Family members					
Members of my Religious group					
Self-help group members					
other					
Other:					

SECTION B: INFORMATION ON RECOVERY

Below is a list of statements that describe how you sometimes feel about yourself and your life. Kindly circle the number to the right that best describes the extent to which you agree or disagree with the statement. Select only one number for each statement.

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
1. I have a desire to succeed.	1	2	3	4	5
2. I have my own plan for how to stay or become well.	1	2	3	4	5
3. I have goals in life that I want to reach.	1	2	3	4	5
4. I believe I can meet my current personal goals.	1	2	3	4	5
5. I have a purpose in life.	1	2	3	4	5
6. Even when I don't care about myself, other people do.	1	2	3	4	5
7. Fear doesn't stop me from living the way I want to.	1	2	3	4	5
8. I can handle what happens in my life.	1	2	3	4	5

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
9. I like myself.	1	2	3	4	5
10. If people really knew me, they would like me.	1	2	3	4	5
11. I have an idea of who I want to become	1	2	3	4	5
12. Something good will eventually happen.	1	2	3	4	5
13. I'm hopeful about my future.	1	2	3	4	5
14. I continue to have new interests.	1	2	3	4	5
15. Coping with my mental illness is no longer the main focus of my life.	1	2	3	4	5
16. My symptoms interfere less and less with my life.	1	2	3	4	5
17. My symptoms seem to be a problem for shorter periods of time each time they occur.	1	2	3	4	5

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
18. I know when to ask for help.	1	2	3	4	5
19. I am willing to ask for help.	1	2	3	4	5
20. I ask for help, when I need it.	1	2	3	4	5
21. I can handle stress.	1	2	3	4	5
22. I have people I can count on.	1	2	3	4	5
23. Even when I don't believe in myself, other people do.	1	2	3	4	5
24. It is important to have a variety of friends.	1	2	3	4	5

SECTION C: INFORMATION ON SOCIAL INCLUSION

The table below contains statements that describe your relations with other people. Kindly circle the number to the right that best describes the extent to which you agree or disagree with the statements. Kindly select one option for each statement.

	Not at all	**Not particularly**	**Yes a bit**	**Yes definitely**
1. I have friends I see or talk to every week	1	2	3	4
2. My social life has been mainly related to mental health services or people who use services	4	3	2	1
3. I have been involved in a group, club or organisation that is not just for people who use mental health services	1	2	3	4
4. I have learnt something about other people's cultures	1	2	3	4
5. I have been to new places	1	2	3	4
6. I have felt accepted by my friends	1	2	3	4
7. I have felt accepted by my family	1	2	3	4
8. I have felt accepted by my neighbours	1	2	3	4
9. I have felt that some people look down on me because of my mental illness	4	3	2	1
10. I have felt it was unsafe to walk alone in my neighbourhood in daylight	4	3	2	1
11. I have been out socially with friends (for example to the wedding, funeral, stadium, and clubs)	1	2	3	4
12. I have done some cultural activities (for example gone to funeral, festival, wedding, or engage in traditional dance)	1	2	3	4
13. I have felt clear about my rights	1	2	3	4
14. I have felt free to express my beliefs (for example political or religious beliefs)	1	2	3	4
15. I have felt that I am playing a useful part in society	1	2	3	4
16. I have felt that what I do is valued by others	1	2	3	4

SECTION D: SELF-HELP GROUPS, RECOVERY AND SOCIAL INCLUSION.

A list of statements on how mental health self-help groups could influence your life have been provided in the table below. Kindly select the statements that apply to you by ticking in the boxes under the yes column.

My participation in self-help group has:

		Yes	No
1	Aided me to access financial resources		
2	Aided me to access medication		
3	Increased my social support network		
4	Improved the quality of support I receive from people		
5	Improved my adherence to treatment plan, including taking my medication on time and meeting mental health professionals when needed.		
6	Improved my relations with family members		
7	Improved the quality of care I receive from family members and/or caregiver/s		
8	Improved on my self-esteem/self-worth		
9	Improved on my ability to do things for myself (self-efficacy)		
10	Improved on my ability to integrate into society. Example to attend funeral, wedding, and associate with others.		
11	Enabled me to cope with my psychiatric symptoms better		
12	Increased my knowledge about my condition, and resources available for me in my community		
13	Helped me to cope with stigma better		

14. Please state other ways (if any) that self-help group has facilitated your recovery and social inclusion:

……

……

……

Please provide your contact details below:

Telephone number …….

Email …….

Researcher's address:

Telephone: 0501350760/0242527934

Email: aamponsah023@st.ug.edu.gh

THANK YOU FOR PARTICIPATING!

Appendix 2: Questionnaire for non-self-help group members

University of Ghana

College of humanities

School of social Sciences

Department of Social Work

This questionnaire seeks to solicit responses from you as a means of gathering data on the topic "**the role of mental health self-help groups in the recovery and social inclusion of persons with mental disorders."**

INSTRUCTION: Please Answer all questions in this questionnaire.

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

TODAY'S DATE **……**

1. Sex? Male ☐ Female ☐

2. Age ……

3. Highest level of education?

None ☐ Primary ☐ Junior High School ☐

Senior High School ☐ Tertiary ☐

4. Religion

Christian ☐ Muslim ☐ Traditionalist ☐

others (please specify) …….

5. What is your current marital status?

Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed ☐

6. In which year where you diagnosed with mental health problem?

…….

7. How long have you been on psychiatric treatment for your mental health problem?

……

8. What is your current employment status?

Employed ☐ Self Employed ☐ Unemployed ☐

9. Name of hospital where you access mental health service

……
…..

10. Since the onset of your mental health problem, which of the categories of people below have been helpful to you (select all that apply to you)?

Neighbors ☐ Friends ☐ Family members (both nuclear and extended) ☐

Members of my Religious group ☐

Others:……
……
……

11. How will you evaluate the quality of support provided to you by the category of people listed in the table below, since the onset of your mental health problem?

	Extremely poor	**poor**	**Normal**	**Good**	**Excellent**
Neighbours					
Friends					
Family members					
Members of my Religious group					
other					
Other:					
Other:					

SECTION B: Information on recovery

Below is a list of statements that describe how you sometimes feel about yourself and your life. Kindly circle the number to the right that best describes the extent to which you agree or disagree with the statement. Select only one number for each statement.

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
1. I have a desire to succeed.	1	2	3	4	5
2. I have my own plan for how to stay or become well.	1	2	3	4	5
3. I have goals in life that I want to reach.	1	2	3	4	5
4. I believe I can meet my current personal goals.	1	2	3	4	5
5. I have a purpose in life.	1	2	3	4	5
6. Even when I don't care about myself, other people do.	1	2	3	4	5
7. Fear doesn't stop me from living the way I want to.	1	2	3	4	5
8. I can handle what happens in my life.	1	2	3	4	5
9. I like myself.	1	2	3	4	5
10. If people really knew me, they would like me.	1	2	3	4	5
11. I have an idea of who I want to become	1	2	3	4	5

12. Something good will eventually happen.	1	2	3	4	5
13. I'm hopeful about my future.	1	2	3	4	5
14. I continue to have new interests.	1	2	3	4	5

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
15. Coping with my mental illness is no longer the main focus of my life.	1	2	3	4	5
16. My symptoms interfere less and less with my life.	1	2	3	4	5
17. My symptoms seem to be a problem for shorter periods of time each time they occur.	1	2	3	4	5
18. I know when to ask for help.	1	2	3	4	5
19. I am willing to ask for help.	1	2	3	4	5
20. I ask for help, when I need it.	1	2	3	4	5
21. I can handle stress.	1	2	3	4	5
22. I have people I can count on.	1	2	3	4	5
23. Even when I don't believe in myself, other people do.	1	2	3	4	5
24. It is important to have a variety of friends.	1	2	3	4	5

SECTION C: INFORMATION ON SOCIAL INCLUSION

The table below contains statements that describe your relations with other people. Kindly circle the number to the right that best describes the extent to which you agree or disagree with the statement. Kindly select one option for each statement.

	Not at all	**Not particularly**	**Yes, a bit**	**Yes definitely**
1. I have friends I see or talk to every week	1	2	3	4
2. My social life has been mainly related to mental health services or people who use services	4	3	2	1
3. I have been involved in a group, club or organisation that is not just for people who use mental health services	1	2	3	4
4. I have learnt something about other people's cultures	1	2	3	4
5. I have been to new places	1	2	3	4
6. I have felt accepted by my friends	1	2	3	4
7. I have felt accepted by my family	1	2	3	4
8. I have felt accepted by my neighbours	1	2	3	4
9. I have felt that some people look down on me because of my mental illness	4	3	2	1
10. I have felt it was unsafe to walk alone in my neighbourhood in daylight	4	3	2	1
11. I have been out socially with friends (for example to the wedding, funeral, stadium, and clubs)	1	2	3	4
12. I have done some cultural activities (for example gone to funeral, festival, and wedding)	1	2	3	4
13. I have felt clear about my rights	1	2	3	4

	Not at all	**Not particularly**	**Yes, a bit**	**Yes definitely**
14. I have felt free to express my beliefs (for example political or religious beliefs)	1	2	3	4
15. I have felt that I am playing a useful part in society	1	2	3	4
16. I have felt that what I do is valued by others	1	2	3	4

SECTION D: Opinion on mental health self-help groups

Mental health self-help groups are community-based organizations made up of persons diagnosed with mental disorders, persons with epilepsy, their family members or caregivers. Their main aim is to come together to offer mutual support to members in order to facilitate the recovery journey and caregiving activities of members. Members meet once or twice in a month and sometimes organize activities such as durbars for members to participate. About 569 of self-help groups exist in Ghana.

1. Why do you not participate in self-help group?

……
……
……
……
……
……

2. Under what conditions will you join self-help group?

……
……
……
……

Please provide your contact details below:

Telephone number …….

Email …….

Researcher's address:

Telephone: 0501350760/0242527934

Email: aamponsah023@st.ug.edu.gh

THANK YOU FOR PARTICIPATING!

Appendix 3: Socio-demographic profile of respondents in the qualitative interviews

University of Ghana

College of humanities

School of social Sciences

Department of Social Work

Interview guide for persons with neuropsychiatric disorders who belong to self-help groups.

TODAY'S DATE **…….**
Name……
Pseudonym …… Tel: .....
Time started: ……. Time ended: …….

SECTION A: socio-demographic characteristics of respondents

1. Sex.
Male ☐ Female ☐
2. Age ……

3. Highest level of education attained.
None ☐ Primary ☐ Junior High School ☐
Senior High School ☐ Tertiary ☐
4. Religion
Christian ☐ Muslim ☐ Traditionalist ☐
others (please specify) …….
5. What is your current marital status?
Married ☐ Separated ☐ Divorced ☐ Single ☐
Widowed ☐
6. What is your status in self-help group (example member, leader, or volunteer)?
……
7. How long have you been on biomedical treatment for your mental health problem?
…….
8. How long have you been a member of the self-help group
……

Appendix 4: Interview guide for self-help group members

I am Alexander Amponsah, an MPhil candidate from the Department of Social Work, University of Ghana. I hope that you will open-up to me as we engage in a discussion on your experience in SHGs and how it has facilitated your recovery and social inclusion. You are also reminded (as contained in the consent form) that participation in this interview is voluntary and that you can opt out at any point.

1. How has your experience been as a member of this self-help group?
2. In what ways have your experience in this group affected your life?

   probes:

   How has it impacted on your self-image, self-confidence, hope or resilience?

   How has it impacted on your family and other social relationships?

   How has it impacted on your life goals?

   How has it shaped your level of knowledge and perception about your mental disorder?

   How has it impacted your perceived stigma?

   How has it affected your response to stigma directed against you from society?

   How has it affected your economic life?

3. If you compare your life before and after joining this group, would you say this group has made any difference? What make you say so?
4. If you compare yourself with other persons with mental disorders who do not participate in self-help groups, what make you think that this group is helpful to you or otherwise?
5. What opportunities has this group exposed you to? How have they impacted on your life?
6. What summary will you provide on the role of SHGs in your life?
7. Do you have any final remarks to share?

Thank you for journeying through with me to the end of the interview.

Appendix 5: Interview guide for inactive self-help group members

I am Alexander Amponsah, an MPhil candidate from the Department of Social Work, University of Ghana. I hope that you will open-up to me as we engage in a discussion on your experience in SHGs and how it has facilitated your recovery and social inclusion. You are also reminded (as contained in the consent form) that participation in this interview is voluntary and that you can opt out at any point.

1. How was your experience like when you were a member of self-help group?
2. In what ways did your experience in self-help group affect your life?

   probes:

   How did it impact on your self-image, self-confidence, hope or resilience?

   How did it impact on your family and other social relationships?

   How did it impact on your life goals?

   How did it shape your level of knowledge and perception about your mental disorder?

   How did it impact your perceived stigma?

   How did it affect your response to stigma directed against you from society?

   How did it affect your economic life?

3. If you compare your life before and after joining this group, would you say the group made any difference? What make you say so?
4. What opportunities did the group expose you to? How have they impacted on your life?
5. What summary will you provide on the role of SHGs in your life?

Thank you for journeying through with me to the end of the interview.

Appendix 6: Interview guide for self-help group leaders and volunteers

I am Alexander Amponsah, an MPhil candidate from the Department of Social Work, University of Ghana. I hope that you will open-up to me as we engage in a discussion on your experience in SHGs and how it has facilitated your recovery and social inclusion. You are also reminded (as contained in the consent form) that participation in this interview is voluntary and that you can opt out at any point.

1. How has your experience been as a member of this self-help group?
2. In what ways have your experience in this group affected your life?

probes:

How has it impacted on your self-image, self-confidence, hope or resilience?

How has it impacted on your family and other social relationships?

How has it impacted on your life goals?

How has it shaped your level of knowledge and perception about your mental disorder?

How has it impacted your perceived stigma?

How has it affected your response to stigma directed against you from society?

How has it affected your economic life?

3. If you compare your life before and after joining this group, would you say this group has made any difference? What make you say so?
4. If you compare yourself with other persons with mental disorders who do not participate in self-help groups, what make you think that this group is helpful to you or otherwise?
5. What opportunities has this group exposed you to? How have they impacted on your life?
6. How does the group promote recovery and social inclusion of members?
7. What opportunities do the group expose members to?
8. What summary will you provide on the role of SHGs in your life?

Thank you for journeying through with me to the end of the interview.

Appendix 7: Consent form for respondents in the quantitative study

UNIVERSITY OF GHANA

Official Use only

Protocol number

Ethics Committee for Humanities (ECH)

PROTOCOL CONSENT FORM

Section A- BACKGROUND INFORMATION

Title of Study: The role of mental health self-help groups in the recovery and social inclusion of persons with mental disorders in the Greater Accra Region of Ghana

Principal Investigator: Alexander Amponsah

Certified Protocol Number

Section B– CONSENT TO PARTICIPATE IN RESEARCH

General Information about Research

The purpose of this study is to investigate the influence of self-help groups on the recovery and social inclusion of persons with neuropsychiatric disorders. The study specifically seeks to explore the various ways in which participation in mental health self-help group promotes recovery and social inclusion, and also examine the significance of the contributions of mental health self-help groups by comparing the level of recovery and social inclusion of persons with neuropsychiatric disorders who belong to self-help groups and those who do not. This study is conducted primarily for academic purpose, and it is a core requirement for completing the MPhil Social Work Programme, at University of Ghana.

It will take approximately 40 minutes to complete this questionnaire. You have the choice to answer the questionnaire on your own, a peer interviewer can conduct an interview with you to aid you to respond to the questions.

Benefits/Risks of the study

You will have the opportunity to share your feelings and knowledge on your level of recovery and social inclusion. You can request for your scores to be shared with you so that you will get to know more about your status of wellbeing in relation to recovery and social inclusion. The researcher can as well discuss with you measures to promote your recovery and social inclusion upon request.

There is no health worker present who would provide first aid in case of relapse during the time you spend to answer the questionnaire. You are kindly requested to provide the contact details of a person to contact in case you relapse in the course of participating in the study here:
NAME: …… TEL: …….

Confidentiality

You are assured that your responses will only be used for the purpose for which the study is conducted. The data you provide will be shared with my two supervisors and lecturers at the Department of Social Work, University of Ghana as and when the need arises. The peer interviewers will also have access to the data. The hard copies of data collected will be kept in my wardrobe and locked up whenever I am not working on it. The softcopy of the data will be saved in a folder on my personal laptop and in my iCloud account both of which would be sealed with a password.

Compensation

Kindly take note that no amount of money would be paid to you for participating in this study.

Withdrawal from the Study

You are notified that participation in this study is strictly voluntary, and that you can choose to opt out from it at any point in the course of data collection. You will not be adversely affected in anyway if you choose to opt out of the study. You are kindly informed that your participation will be terminated if you relapse in the course of participation.

Contact for Additional Information

If you want any additional information, or questions you can contact the principal investigator through the address below.

Alexander Amponsah, MPhil candidate at Department of Social Work, University of Ghana, Legon.

Email: aamponsah023@st.ug.edu.gh; Tel: 0501350760 / 0242527934.

If you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at:

ech@ug.edu.gh or 00233- 303-933-866.

Section C- PARTICIPANT AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive xa copy for my personal records."

_____

Name of Participant _____

_____

Signature or mark of Participant Date

If participant cannot read and or understand the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_____

Name of witness

_____ _____

Signature of witness / Mark Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_____

Name of Person who Obtained Consent

_____ _____

Signature of Person Who Obtained Consent Date

Appendix 9: consent form for respondents in the qualitative study

UNIVERSITY OF GHANA

Official Use only

Protocol number

Ethics Committee for Humanities (ECH)

PROTOCOL CONSENT FORM

Section A- BACKGROUND INFORMATION

Title of Study: The role of mental health self-help groups in the recovery and social inclusion of persons with mental disorders in the Greater Accra Region of Ghana

Principal Investigator: Alexander Amponsah

Certified Protocol Number

Section B– CONSENT TO PARTICIPATE IN RESEARCH

General Information about Research

The purpose of this study is to investigate the influence of mental health self-help groups on the recovery and social inclusion of persons with mental disorders. The study specifically seeks to explore the various ways in which participation in mental health self-help group promotes recovery and social inclusion, and also examine the significance of the contributions of mental health self-help groups by comparing the level of recovery and social inclusion of persons with mental disorders who belong to mental health self-help groups and those who do not. This study is conducted primarily for academic purpose, and it is a core requirement for completing the MPhil Social Work Programme, at University of Ghana.

It will take approximately 50 minutes to conduct this interview.

Benefits/Risks of the study

The process of discussing and sharing of experiences on the topic can be therapeutic for you. Participating in this study is a sign of empowerment since you could share your knowledge and experience with many people who will read the research report.

There is no health worker present who would provide first aid in case of relapse during the time you spend to answer the questionnaire. You are kindly requested to provide the contact details of a person to contact in case you relapse in the course of participating in the study here:
NAME: …… TEL: ……

Confidentiality

You are assured that your responses will only be used for the purpose for which the study is conducted. The information you provide will be shared with my two supervisors and lecturers at the Department of Social Work, University of Ghana as when the need arises. The data will be saved in a folder on my personal laptop and in my iCloud account both of which would be sealed with a password.

Compensation

You will be provided with one bottle of water and a can of malt for participating in this interview. The water can be taken anytime from the start to the end of the interview, but the can of malt will be accessible only after the interview has ended. Kindly take note that no amount of money would be paid to you for participating in this study.

Withdrawal from Study

You are notified that participation in this interview is strictly voluntary, and that you can choose to opt out from it at any point during the interview. You will not be adversely affected in anyway if you choose to opt out of the study. You are kindly informed that your participation will be terminated if you relapse in the course of participation.

Contact for Additional Information

If you want any additional information, or questions you can contact the principal investigator through the address below.

Alexander Amponsah, MPhil candidate at Department of Social Work, University of Ghana, Legon.

Email: aamponsah023@st.ug.edu.gh; Tel: 0501350760 / 0242527934.

If you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at:

ech@ug.edu.gh or 00233- 303-933-866.

Section C- PARTICIPANT AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

_____

Name of Participant _____

_____

Signature or mark of Participant Date

If participant cannot read and or understand the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_____

Name of witness

_____ _____

Signature of witness / Mark Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_____

Name of Person who Obtained Consent

_____ _____

Signature of Person Who Obtained Consent Date

Appendix 10: Ethical Clearance

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

January 14th, 2020

Ref. No.:.....

Alexander Amponsah
Department of Social Work
University of Ghana
Legon

ETHICAL CLEARANCE
(ECH 053/ 19-20)

On December 18th, 2019 the University of Ghana – Ethics Committee for the Humanities (ECH) at a full committee meeting reviewed and approved your protocol as follows:

TITLE OF PROTOCOL: **THE ROLE OF MENTAL HEALTH SELF-HELP GROUP IN THE RECOVERY AND SOCIAL INCULSION OF PERSONS WITH MENTAL DISORDERS IN THE GREATER ACCRA REGION OF GHANA.**

STUDENT INVESTIGATOR: **ALEXANDER AMPONSAH**

Please note that the final review report must be submitted to the Committee at the completion of the study. Your research records may be audited at any time during or after the implementation. Any modification of this research project must be submitted to ECH for review and approval prior to implementation.
Please report all serious adverse events related to this study to ECH within seven (7) days verbally and in writing within fourteen (14) days.

This certificate is valid till 14th January 2021. You are to submit annual reports for continuing review.

Please accept my congratulations.

Yours Sincerely,

Professor Akosua Darkwah.
ECH Vice-Chair

ECH Committee for Humanities
14 JAN 2021
Valid Until
University of Ghana

COLLEGE OF HUMANITIES
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