

**SCHOOL OF PUBLIC HEALTH  
COLLEGE OF HEALTH SCIENCES  
UNIVERSITY OF GHANA**



**CAREGIVERS PERSPECTIVES ON FACTORS AFFECTING  
MEDICATION NON-ADHERENCE AMONG MENTAL HEALTH  
PATIENTS AT THE PANTANG PSYCHIATRIC HOSPITAL**

**BY**

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**DECLARATION**

I, Genevieve Awuye-Kpobi hereby declare that apart from references to other people's works which have been duly acknowledged, this dissertation is a result of my own independent work and has not been submitted for the award of any degree in any institution.

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## **DEDICATION**

I dedicate this dissertation to my family, most especially my husband, for his guidance, and motivation.

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## ABSTRACT

**Background:** The burden of mental and behavioral disorder has increased by 38% from 1990 to 2010 globally. In developing and under-developed income countries over 70% of this increase is due to mental disorder. In Ghana the prevalence of mental disorders has been estimated at 13% of the adult population. The purpose of the study was to examine caregivers' perspectives on factors affecting medication non-adherence among mental health patients at the Pantang Psychiatric Hospital.

**Methods:** The study relied on qualitative design with a phenomenological approach to examine the objectives of the study. In all, twenty (20) caregivers ranging from prescribers, nurses and relatives were interviewed face-to-face. Above all the study adapted the health belief model.

**Results:** The study found among others that patients-related factors affecting medication non-adherence among mental health patients include side effect of medication, financial challenges, lack of insight, family influence, religious belief, length of time of taking the medication, inflated cost of care and non-availability of the medication. Also found in the study was pharmacological factors such as restlessness, tardive dyskinesia, Parkinsonism which has really affected non-adherence of medication. The study therefore recommend that Government or policy makers must improve mental health in Ghana, policies must be developed to include mental health services into NHIS which will reduce the burden of cost on the clients, the use of atypical and long acting medications must be promoted and constant training and supervision of mental health workers to perform standard psycho-education regularly at the facility.

**Conclusion:**

The findings revealed several factors of medication non-adherence from patients-related, to institutional, community and pharmacological factors, thereby providing insight into different non-adherence factors. Clarity is offered by highlighting religious differences and similarities in mental health beliefs and perceptions about the causes of mental health problems. The implications of the studies and recommendations are based on current findings.

## TABLE OF CONTENTS

DECLARATION .....	i
DEDICATION .....	ii
ACKNOWLEDGEMENT .....	iii
ABSTRACT.....	iv
TABLE OF CONTENTS.....	vi
LIST OF TABLES .....	x
LIST OF ABBREVIATION.....	xi
CHAPTER ONE .....	1
INTRODUCTION .....	1
1.0 Background of the Study.....	1
1.1 Problem Statement .....	5
1.2 Objectives.....	6
1.2.1 General Objectives .....	6
1.2.2 Specific Objectives .....	6
1.3 Research Questions .....	7
1.4 Justification .....	7
1.5 Definition of Terms.....	8
CHAPTER TWO .....	9
LITERATURE REVIEW .....	9
2.0 Introduction .....	9
2.1 Measurement of non- adherence .....	9
2.2 Determinants of medication non-adherence.....	11
2.2.1 Patients –related factors.....	12
2.2.2 Pharmacological factors .....	15
2.3 Effects of non-adherence.....	17
2.4 Caregivers and caregiving.....	19
2.5 Theoretical model.....	21
2.5.1 The health belief model .....	21
2.5.2 The trans theoretical model and the precaution adoption model.....	24
2.5.3 The self-medication hypothesis .....	25
CHAPTER THREE .....	27
METHODOLOGY .....	27
3.0 Introduction .....	27

3.1 Study Design .....	27
3.2. Study Area.....	28
3.3 Study Population .....	28
3.4 Selection Technique .....	28
3.5 Inclusion criteria.....	29
3.6 Exclusion criteria.....	29
3.7 Data collection.....	30
3.7.1 Data Collection Instrument.....	30
3.7.2 Data collection mode .....	31
3.8 Data Analysis .....	32
3.9 Ethical considerations .....	33
3.10 Quality Control.....	33
CHAPTER FOUR.....	35
RESULTS .....	35
4.0 Introduction .....	35
4.1 Background Characteristics of Participants .....	35
4.2 Patients-related factors and how it affects medication non-adherence among mental health patients.....	36
4.2.1 Financial Challenges.....	37
4.2.2 Distance .....	38
4.2.3 Lack of Insight into condition .....	38
4.2.4 Family Influence.....	40
4.2.5 Religious Beliefs.....	40
4.2.6 Superstition.....	41
4.2.7 Stigmatization.....	42
4.2.8 Health Beliefs and Religion.....	43
4.2.9 Type of disorder, poor understanding of medication, and lack of involvement in decision making.....	45
4.2.10 Forgetfulness .....	45
4.3 Institutional Factors Affect Medication Non-Adherence in Mental Health Patients .....	45
4.3.1 Cost of Care (Cost of Medication, Cost of Admission) .....	46
4.3.2 Attitude of Health Workers, Ineffective Communication .....	49
4.3.3 Non-availability of the medication .....	51
4.4 Community Factors Affect Medication Non-Adherence in Mental Health Patients .....	52
4.5 Pharmacological factors affect medication non-adherence.....	55

4.5.1 Side Effect of Medication.....	57
4.5.2 Fear of Harmful Effect of The Drugs .....	57
4.5.3 Length of Time of Taking the Medication .....	58
4.5.4 Type of medication, side effect of medication, frequency of medication, number of medications taken. ....	58
4.6 Strategies Put in Place .....	60
4.6.1 Persuasion and Being Nice .....	60
4.6.2 One on One Consultation .....	61
4.6.3 Simple equation plan (client name plus medicine).....	61
4.6.4 A stop to stigmatization.....	61
4.6.5 Education on their Condition.....	61
4.6.6 Dealing with Cost .....	62
CHAPTER FIVE .....	63
DISCUSSIONS.....	63
5.0 Introduction .....	63
5.1 Patients-related factors affecting medication non-adherence among mental health patients. ....	63
5.1.1 Lack of Insight into condition .....	63
5.1.2 Financial Challenges.....	64
5.1.3 Family Influence.....	64
5.1.4 Religious Beliefs.....	64
5.1.5 Superstition.....	65
5.1.6 stigmatization.....	66
5.1.7 Length of Time of Taking the Medication .....	66
5.1.8 Non-Availability of The Medication .....	66
5.2 Institutional factors affect medication non-adherence in mental health patients .....	66
5.2.1 Cost of medication and admission.....	66
5.2.2 Attitude of Health Workers, Ineffective Communication .....	67
5.2.3 Forgetfulness .....	67
5.3 Community factors that affect medication non-adherence among mental health patients. ....	67
5.4 Pharmacological factors .....	68
CHAPTER SIX.....	70
CONCLUSIONS AND RECOMMENDATIONS .....	70
6.0 Introduction .....	70
6.1 Summary of findings.....	70

6.2 Conclusion.....	71
6.3 Recommendations .....	71
REFERENCES .....	73
APPENDICES .....	81
Appendix A: Informed Consent Form .....	81
Appendix B: In-depth interview guide for care-givers .....	84

**LIST OF TABLES**

Table 4.1: Demographic Profile of the Respondents.....36

### **LIST OF ABBREVIATION**

HIV	Human Immune Deficiency Syndrome
ICD	International Classification of Diseases
IDI	In - Depth Interview
NHIS	National Health Insurance Scheme
OPD	Out-Patients Department
PPH	Pantang Psychiatric hospital
PTSDS	Post Traumatic Stress Disorder

## CHAPTER ONE INTRODUCTION

### 1.0 Background of the Study

Mental wellbeing has been well defined by the ( World Health Organization, 2013) as “a state of health in which every individual recognizes his or her own potential, can cope with the normal stresses of life, can work effectively, and is able to make a contribution to his or her community”. Mental illness affects all ages, ethnic, racial, socio-economic and cultural groups (USDOHAHS Mental Health, 2001). The problem of mental and behavior disorder has increased by 38% from 1990 to 2010 universally (Murray et al., 2013).

In developing and under-developed income countries over 70% of this increase is due to mental disorder. In Ghana the occurrence of mental illness has been predicted at 13% of the grown-up population.(Lopez, Mathers, Ezzati, Jamison, & Murray, 2006).The International Classification of Diseases (ICD) is an international standard diagnostic classification for a wide variety of health conditions. The ICD-10 states that mental disorder is "not an exact term", even though is usually used "...to suggest the presence of a clinically recognizable set of signs or behaviors related in most instances with anguish and with interference with individual functions"(World Health Organization, 1992).

Mental health disorders are normally classified using the International Classification of Diseases (ICD-10) or the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 2000; World Health Organization, 2011). ICD-10 categories mental health issues into ten main groups including: schizophrenia/schizotypal disorders; affective disorders (e.g. depression); neurotic/stress-related disorders (e.g. anxiety); personality disorders (e.g. psychopathy); disorders of psychological development; and, disorders linked to the use of psychoactive substances (e.g. alcohol) Mental retardation,

disorder of psychological development, behavioral and emotional disorders with onset usually occurring in childhood and adolescence, in addition, a group of unspecified mental disorders.(World Health Organization, 2011) .

In Ghana, by policy, accessibility to mental health treatment is free of charge at the government hospital. However, if there is shortage of medication in the hospital, patients have to buy privately since the National health insurance scheme ( NHIS) does not include mental health services (Ofori-Atta, Read, & Lund, 2010)

Mental disorders mostly do well on psychological and social interventions and medication for recovery (Jenkins & Baingana, 2010). Psychosocial mediation usually include cognitive behavioral remedy, adherence treatment, and psycho-education (Velligan et al., 2009).

WHO (2003) define Adherence as “the degree to which a person's medication taking behavior, eating habit as well as changes in one’s way of life agrees with prescription from health service provider. As soon as a patient stops his/her medication prescribed by a medical expert for the management of a disease, this conduct is termed ‘non-compliance’ or ‘non-adherence’(Dodds, Rebar-Brown, & Parsons, 2000; Haynes, McDonald, & Garg, 2002) ‘Non-adherence’ can also be well-defined as the choice of the patient not to take prescribed medication, while not entirely flouting other medical advice (Dodds et al., 2000). Previous reports of medication adherence prevalence for persons with mental disease have ranged from 8% to 85%, with the greatest adherence rates evaluated between 40% and 70% (Clatworthy, Bowskill, Rank, Parham, & Horne, 2007; Gray, White, Schulz, & Abderhalden, 2010a; Lingam & Scott, 2002). Absence of social help, intellectual shortfalls, and a poor restorative organization together (Acosta et al., 2012) have been appeared to be solid forecasters for non-adherence, which, thus, is related to high danger of relapse, hospitalization, and antipsychotic

management obstruction on one hand and with substance utilization, savagery, arrests, suicide endeavors, and disabled long term functioning on the other hand (Hofer & Fleischhacker, 2011).

Caregiving refers to the assistant and support provided daily to individuals who are either temporarily or permanently handicapped (LA Public Health, 2010)

Informal caregivers are usually family members or near relations of the recipient; such informal caregivers are not paid for their services (Schulz & Sherwood, 2008) Formal caregivers on the other hand are those giving care to someone; an individual and has some formal training in such act, and paid to provide such care (Waldrop, 2006).

Generally, caregivers are considered as 'pillars of recovery', where caregivers for people with mental illness are assigned with responsibilities beyond support. Family caregivers as patient advocate, go through diverse issues which often put extra weight on the relationship between the caregiver and formal care services that may be supportive of the patient (Goodhead & McDonald, 2007). Such issues are generally classified as caregiving burden which could be subjective or objective. Impartial burden relates to the patient's symptoms, behavior, and socio-demographic features, and aspects such as changes in domestic routine, family relations, work, rest time, and physical health: subjective burden is the mental health and subjective emotional agony among family members (Son et al., 2007).

Research has shown that caregivers report high levels of burden related to taking care of their mentally challenge family members as they face both the day- to- day stressors of unpredictable and weird behaviors of their relative with mental health disorder, as well as the emotional frustrations such as guilt and isolation, and family conflicts (Chan, Yip, Tso, Cheng, & Tam, 2009; Read, Adiibokah, & Nyame, 2009; Saxena, Thornicroft, Knapp, & Whiteford, 2007). The burden experienced is underlined by the stigma and cultural memory that effectively undermines the social standing of every family member of the mental health

patients (Hanzawa, Tanaka, Inadomi, Urata, & Ohta, 2008; Quinn, 2007). Since the 1950's, researchers have been exploring the consequences of mental illness on patients' caregivers (Jungbauer, Wittmund, Dietrich, & Angermeyer, 2004). Studies report a high degree of burden in caregivers (Jungbauer et al., 2004) These studies explore how much family caregivers can offer aid to the loved one with a severe mental illness before they become overworked and need specialist help. Estimates by (McDonnell, Short, Berry, & Dyck, 2003) are that up to 80% of people with mental illness lives with a family member or caregiver. Caregivers obviously perform a substantial role in the life of a person with mental disorders. They provide direct assistance, advocate for services and provide financial and emotional support. Caregivers can have immersed influence on the ability of persons with mental health issues to live productive, integrated lives in their communities.

Caregivers also play a key but relatively unexplored role in assisting their relatives in taking their medications and maintaining stability in the community (McDonnell et al., 2003). Strong social support, including family and society supports and a good affiliation with the care team, has been reported to positively influence medication adherence. Studies also have shown that when a patient relative takes the role of a caregiver, it leads to positive effect on patients taking their medications (Farmer, Walsh, & Bentley, 2006). As medication adherence affects all parties, adherence to medication in mentally ill persons holds the possibility of reducing disease and suffering of patients and caregivers, in addition to decreasing the price of re-hospitalization.

In Ghana, mental health is still in its infancy in terms of spread, development and resources. For example, in primary health care, there are no expert doctors in mental health, and in 2008 there were only 10 psychiatrists in Ghana, compared to a 13074 doctors to Ghana's population of 24,252,438 (Doku, & Awakame, 2012; Ofori-Atta & Ohene, 2015). This

situation forces caregivers to be the main bulwark of care and support for patients, or else the patient will be vulnerable to relapse and readmission (Chien & Wong, 2007).

### **1.1 Problem Statement**

Globally, it is assessed that the disease burden of mental health disease accounts for 32.4% of years lived with incapacity and 13.0% of disability-adjusted life years. These estimates place mental illness in the leading position compared to other diseases in term of years lived with incapacity (Vigo, Thornicroft, & Atun, 2016).

Non-adherence to prescribed medication regime for mental health illness has been observed as a problem universally and may be the most thought-provoking aspect of managing mentally challenged patients (WHO, 2003). Ideally, full adherence or good adherence to prescribed medication should be 80% or more ((Kane, Kishimoto, & Correll, 2013). However a study conducted in Ghana among caregivers of mental health patients stated non-adherence to psychotropic medicines among patients with schizophrenia as 54.5% ((Kretchy, Osafo, Agyemang, Appiah, & Nonvignon, 2018). Using this study as the current situation to non-adherence to psychotropic medication in Ghana, gives a gap of 25.5% away from the ideal situation.

Poor adherence to psychotropic medication poses significant community health consequences. This is because poor adherence to prescribed medication affects treatment outcomes and reduces the certainty of the action of the medication. This heightens the probability of symptoms relapse (Crowe & Wilson, 2011; Gray, White, Schulz, & Abderhalden, 2010). In addition, it prolongs recovery time and results in regular hospitalizations, as well as continuous functional impairment (Cramer & Rosenheck, 1998). Consequences of medication non-adherence can possibly results in low value of life for patients, their relatives and careers, it will also results in increased economic and social

burden as the government will have to allocate resources for care (Ascher-Svanum et al., 2006; Gray et al., 2010a; Jeste et al., 2003).

In view of the consequences of non-adherence to psychiatric medicines, this study seeks to identify the factors affecting medication non-adherence among mental health patients at the Pantang psychiatric hospital as reported by caregivers. Findings from this study can be used to increase awareness among medical officers and other health professionals, including managers of healthcare institutions, to improve approaches to mental health services and aid in reducing non-adherence to medication. In addition, it will add and enrich existing knowledge in literature.

## **1.2 Objectives**

### **1.2.1 General Objectives**

The general objective of this study was:

To explore care-givers perspectives on factors affecting medication non-adherence among mental health patients.

### **1.2.2 Specific Objectives**

Specifically, the study sought to:

- 1) To find out patients-related, factors affecting medication non-adherence among mental health patients.
- 2) Identify institutionalize factors that affect medication non-adherence among mental health patients.
- 3) Find out pharmacological factors that affect medication non-adherence among mental health patients.
- 4) To identify community factors that affect medication non-adherence among mental health patients

### **1.3 Research Questions**

- 1) What patients-related, factors affect medication non-adherence among mental health patients?
- 2) What institutional factors affect medication non-adherence among mental health patients?
- 3) What pharmacological factors affect medication non-adherence?
- 4) What community factors affect medication non-adherence among mental health patients?

### **1.4 Justification**

In Ghana, there is so far, no statistics regarding factors affecting medication non-adherence among mental health patients. Relapse of mental health cases is gradually increasing due to medication non-adherence (Murray et al., 2013). Most patients are brought to the hospital very aggressive, verbally abusive, and destructive. Mental health administrations are looked with a considerable measure of difficulties which somehow influences psychological wellness of clients. This is aggravated by patient's psychological, social and natural factors that can worsen side effects that in the long run prompt relapse.

This research is imperative since it will help in understanding the elements impacting medicine non-adherence in mental health patients. The discoveries will give an establishment compelling nursing mediation and help shape attendants 'and therapist discernments and their perception of patients' worries and encounters about pharmaceutical non-adherence. Information of these variables would enable mental health specialist to enhance the models of mental health consideration and intercessions that are right now connected in nurturing in-patients and out patients with mental confusion in our setting and the entire nation on large.

This research would again set the basis for impending research on drugs non-adherence in mental health patients. Basing on authorize based practice, future research will empower, mental health service specialist co-ops to recognize new medications for nurturing psychological well-being of patients and along these lines diminish relapse rates in patients.

It additionally can possibly impact health policy makers in enhancing mental health and lessening the weight of relapse and re-hospitalization in patients with mental turmoil, their families and network.

### **1.5 Definition of Terms**

Caregivers: Are people who assist in the management of illness or disability in the home or health facility.

Adherence: Is the degree to which patients agrees with approved recommendation from a health provider.

Non –adherence/ Compliance: Refusal of person not to take prescribed medication

Qualitative Analysis: Is the methodical gathering and study of individual interpretation of events with actions in which there is a least of researcher-imposed control

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

Literature review aims at identifying and examining research formerly undertaken surrounding caregivers' perspective on factors affecting medication non-adherence among mental health patients-. The literature review is divided into 4 sections, which include measurement of non-adherence, determinant of non-adherence, effects of non-adherence and caregiver and caregiving including theories relevant to the study.

#### **2.1 Measurement of non- adherence**

Mental disorders mostly do well on psychological and social interventions and medication for recovery (Jenkins & Baingana, 2010).

Practitioners requires much effort to guess which of their patients are non-adherent (Lindstrom, Eriksson, & Levander, 2012; Misdrahi, Petit, Blanc, Bayle, & Llorca, 2012; Sawada et al., 2012). Olivares et al.( 2013) surveyed 4722 psychiatric specialists over 36 countries. Psychiatric specialist approximates that 53% of their patients with schizophrenia were not adhering, implying that they acknowledge the significance of non-adherence. Nevertheless, recognizing the patients who are not adhering may be a task.

Stephenson, Tunceli & Gu (2012) asked US physicians to rate the adherence of individual patients with bipolar disorder and/or schizophrenia and found that 72% of patients whose prescription refill records indicated non-adherence were rated as adherent by their physician. Thus, there is evidence that non-adherence may be recognized as an entire issue but remains hidden within individual consultations. Patients may be afraid that the physicians will interpret a lack of faith in their medicine as representing a lack of faith in them, and therefore be unwilling to raise their concerns and doubts with their physicians. A strong, trusting

relationship between patients and physicians may therefore protect against non-adherence, as firmly established by a new meta-analysis that discovered that, where the relationship between clinicians and patients was strong, patients were highly likely to adhere.

Thompson & McCabe (2012) identified 23 studies relevant to this topic and suggested that future studies should focus on objective assessments of the content of clinical interactions. In one study that did directly assess consultation content, (Quirk, Chaplin, Hamilton, Lelliott, & Seale, 2013) analyzed recordings of 92 consultations that contained discussion of antipsychotic medications between patients and nine UK psychiatrists. Non-adherence was revealed in 22 consultations and most frequently resulted in a prescription change in accordance with the behavior of the patient (Quirk et al., 2013). The researchers suggest that physicians may prevent risking conflict around medication adherence in order to maintain patients' engagement with treatment regime. However, research on the causes of non-adherence suggests that addressing patients concerns about medication directly may be critical to supporting adherence (Bowskill, Clatworthy, Parham, Rank, & Horne, 2007; Clatworthy et al., 2009; National Institute for health and Clinical Excellence, 2009).

Another scientific categorization of adherence definition has been created to improve consistency in the phrasing used to portray adherence (Vrijens et al., 2012). This depicts adherence as being, commencement (taking the principal measurements of the drug, stopping, (never again taking the solution) and usage (regardless of whether the patient's genuine conduct compares to the endorsed dosing treatment in the period from inception to cessation). Inside this scientific classification, determination alludes to the time amongst inception and the last dosage of the solution. Usage non-adherence can incorporate a scope of contrasts between the genuine regimen executions and that endorsed, including missing dosages, taking an alternate measurement of medicine than that recommended and taking drug at

various term. Distinctive appraisal strategies can be utilized to recognize these contrasting sorts of non-adherence; for instance, Yang et al., (2012) utilized pill checks to decide if the patient had taken the right number of measurements, and electronic observing to evaluate whether patients had taken these dosages as recommended.

Different researchers have utilized non-industriousness with a regimen to survey non-adherence, frequently utilizing drug store refill e.g. (Lim et al., 2012; Offord, Lin, Mirski, & Wong, 2013). Through fathoming the diverse parts of adherence estimated by these appraisals, we can value an absence of correspondence amongst estimations and start to investigate whether distinctive examples of adherence have distinctive causes and outcome. Ongoing exploration has featured distinctive examples of non-adherence. Jaeger, Pfiffner and Weiser (2012) utilized idle class investigation to amass 371 in-patients with schizophrenia based on their scores on the on the Medication Adherence Rating Scale at gauge, a self-report/clinician-report apparatus. They distinguished five gatherings of patients based on their adherence reactions and found that distinctive examples of adherence were related with various rates of later suspension and hospitalization. Chang et al., (2012) Categorized schizophrenic patients based on kind of non-adherence as estimated by drug store refill and found that distinctive examples of non - adherences were related with various antipsychotic drugs. Offord et al., (2013) built up that patients with schizophrenia who had early non-adherence inside 90 long stretches of beginning another medicine had lesser adherence for the accompanying a year.

## **2.2 Determinants of medication non-adherence**

These are the factors that contribute to medication non-adherence among mental health patients. These factors were research findings of various researchers in literature

### **2.2.1 Patients –related factors**

Patient-related factors are those factors that emanate from the patient.

#### **2.2.1.1 Lack of insight into condition**

Staring, van der Gaag, Duivenvoorden, Weiden, and Mulder (2011) found that an absence of understanding, and specifically low acknowledgment of the significance for treatment, was emphatically connected with non-adherence inside a small number of patients with schizophrenia. This outcome was particularly solid when patients had great verbal memory. Indeed, even where commonsense hindrances are essential, they may strengthen or cross with perceptual obstructions. For example, a cross-sectional survey of 24017 USA patients with chronic illnesses, including depression, found that perceptual determinants predicted reported unintentional non-adherence (e.g. forgetting, running out of medication, affordability), suggesting that motivational factors can have effect on both perceptual and practical barriers to adherence (Gadkari & McHorney, 2012).

Patients with an absence of understanding into their mental issue have likewise been observed to be in danger of non-adherence (Misdrahi et al., 2012). These examinations represented that motivational variables go past information of drug adequacy and serious impacts.

#### **2.2.1.2 Health belief**

The key part of solution convictions in adherence is clarified by an ongoing subjective blend of research on this theme in-patients with schizophrenia, which featured convictions about control, reliance and shame (Seeman, 2012). Richardson, McCabe & Priebe (2013) led a meta-investigation of the relationship between pharmaceutical mentalities and adherence in patients with psychoses, discovering, 14 ponders demonstrating a little to direct affiliation. A requirement for more imminent and mediation contemplates was recognized

### **2.2.1.3 Type of disorder**

Co-morbid psychiatric conditions can themselves be risk factors for non-adherence. Depression and substance abuse have both been associated to non-adherence within patients with psychiatric diagnoses (Jonsdottir, Opjordsmoen, Birkenaes, 2012; Montes, Maurino, de Dios, & Medina, 2013; Ugarte et al., 2012).

Psychiatric comorbidity is also a risk factor for non-adherence in physical disorders. Ian M. Kronish, Edmondson, Li, & Cohen (2012) found that veterans with post-traumatic stress disorder (PTSD) had increased odds of non-adherence to all medications, relative to veterans without PTSD (OR 1.47), somehow due to increased concerns about the potential unfavorable effects of treatment (Kronish, Goldfinger, Fei, Edmondson, & Horowitz, 2012). In a similar way, Rao et al. (2012) found that non-adherence in HIV patients was predicted by symptoms of depression, which were also connected with increased perceived HIV stigma. Co-morbid psychiatric conditions may therefore have effect on both practical barriers to adherence (e.g. through increased regimen complexity) and perceptual barriers (e.g. through increase concerns) Kazadi, Moosa, & Jeenah, (2008) in their examination which enrolled 217 patients with schizophrenia from emotional wellness outpatient centers in Johannesburg who had gone to the facilities between the period January 1995 and June 2005, they discovered that components which were destined to build the danger of relapse in schizophrenia included co-grim discouraged state of mind and poor medication adherence that was usually caused by patients' poor understanding of the symptoms solutions.

A study by Janssen et al. (2006) took place in seven psychiatric hospitals. Individuals with a psychotic disorder were assessed weekly on mental state, social functioning, side effects and medication compliance. A logistic regression analysis was performed to assess patient and clinical predictors of adherence to medication protocols. The authors found a significant association between lower medication adherence and substance abuse, involuntary

admissions, history of aggressive behavior and no high school graduation. Individuals with pronounced paranoia or negative symptoms were also less adherent in taking their medications (Janssen et al., 2006). Not surprisingly, the authors also found that patient-related factors and family supports, and not just disease-related factors, influence adherence to instructions for taking medication.

Another factor in non-adherence is the symptoms of schizophrenia. For example, delusions may be present, and this delusion may let the patient to believe the medication is poison. Some patients do not take their medications due to confusion, disorganization or other cognitive deficits associated with schizophrenia. Here, the caregiver will need to play a vital role in helping the person with schizophrenia remain on their medicines by providing support and encouragement to take the medications. A few people do not comply with medication protocols out of fear that they will become dependent on or addicted to the drugs (Farmer et al., 2006).

#### **2.2.1.4 Forgetfulness and financial instability**

A study on medication non-adherence among adult mental health out patients in Jimma University specialized ,South west Ethiopia by Tesfay, Girma, Negash, Tesfaye, & Dehning, (2013) revealed that, Out of the 422 patients, 40.3% were females and 59.7% males. The prevalence rate for non-adherence was 41.2%, non-affective psychoses diagnosis contributing the highest rate (44.5%). From the total non-adherent respondents, 78.2% attributed their non-adherence to forgetting. Irregular follow-up, poor social support and complex drug regimen were independently associated variables with non-adherence.

Similarly, a study done in Nigeria among 81 schizophrenic patients who have undergone psychotropic treatment revealed that about 50% did not return for follow-up, and adherence to antipsychotics was poor, even among those who responded well to treatment (Adeponle,

Baduku, Adelekan, Suleiman, & Adeyemi, 2009). The most common reason for defaulting was feeling well, followed by financial instability

## **2.2.2 Pharmacological factors**

### **2.2.2.1 Type of medication**

Certain pharmaceutical treatment is by all accounts related with high adherence because of specific highlights of the drug, for example, symptom profiles (Lim et al., 2012) or diminished dosing recurrence (as appeared by ongoing precise review (Coleman, Limone, & Sobieraj, 2012). Be that as it may, even where regimens are best for adherence by lessening the number or recurrence of measurements, inborn and extraneous inspiration is yet expected to keep up full adherence. Inside the Perception and reasonableness approaches, adherence to pharmaceutical is controlled by both down to earth factors (e.g. assets, quiet limit) and perceptual elements (e.g. convictions about treatment and ailment). Accordingly, endeavors to enhance adherence by attempting to bargain reasonable hindrances alone may not be refined as perceptual boundaries (e.g. questions about solution need or worries about unfavorable outcomes) are imperative for people.

Most customers on normal antipsychotics were found to encounter medicate reactions, for example, tremors, muscle unbending nature, slurred discourse, anxiety, excruciating muscle fits and barrenness which contributed much to their poor adherence. Poor knowledge was found to add to 5.2-times increment in the danger of backsliding in people with poor medication adherence. This has likewise been bolstered by (Li & Arthur, 2005). Their outcomes showed unmistakably that patients who did not hold fast to drug administrations will probably backslide; this was found after they had looked at backslide and adherence after release in a gathering of 89 patients

A study by Janssen et al. (2006) took place in seven psychiatric hospitals. Individuals with a psychotic disorder were assessed weekly on mental state, social functioning, side effects and medication compliance. A logistic regression analysis was performed to assess patient and clinical predictors of adherence to medication protocols. The authors found a significant association between lower medication adherence and substance abuse, involuntary admissions, history of aggressive behavior and no high school graduation. Individuals with pronounced paranoia or negative symptoms were also less adherent in taking their medications (Janssen et al., 2006). The authors also found that patient-related factors and family supports, and not just disease-related factors, influence adherence to instructions for taking medication.

Medication effectiveness is one of the most important issues when prescribing any medication. Thomas (2007) looked at antipsychotic medication effectiveness and adherence. Thomas (2007) discovered that long-term symptom control, tolerability and hence adherence to treatment can all be improved using atypical or second-generation antipsychotic agents compared with typical antipsychotic drugs. He also stated that antipsychotic treatment for schizophrenia should focus on improving real-world outcomes, including functional capacity and health-related quality of life because these factors are important from the patients' perspective and influence medication adherence.

Gianfrancesco, Rajagopalan, Sajatovic & Wang (2006) also looked at adherence from the perspective of typical antipsychotic drugs versus atypical ones and found that each of the atypical studied demonstrated a significantly higher adherence intensity rate than all of the typical combined. These studies are important because the more effective the medication in treatment is, the more likely the patient is to see positive reasons to take the medications. Also, with symptom alleviation, quality of life improves as persons with mental health

disorder can participate in family and community activities. These studies of the effectiveness of medications are also significant as one explores the role of caregivers and medication adherence and non-adherence. It is clear that the more effective the medication, the greater the adherence. More research needs to investigate how medication effectiveness impacts the caregiver role in medication adherence.

#### **2.2.2.2 Side effects of medication**

A study by Mensah and Yeboah (2003) using 1,290 Ghanaian psychiatric patients reported that over 80% stopped or interrupted psychotropic medication due to reasons such as side effects (fatigue and drowsiness), a preference for healing from spiritual churches, and a feeling of recovering.

### **2.3 Effects of non-adherence**

Proof for an effect of non-adherence on results for mental patients has been consolidated inside new research. Non-adherence has been found to prognosticate poorer outcome for patients, including healing center admission San et al., (2013); Wong, Mirski, Lin, & Offord, (2012), forceful conduct Witt, van Dorn, & Fazel (2013), suicide and untimely mortality.

San et al., (2013) examined the therapeutic records of patients with schizophrenia/schizoaffective turmoil admitted to intense care. Out of the 1646 patients on whom information were accessible, for 58.6% of patients the significant explanation behind clinic affirmation was recorded as non-adherence.

Non-adherence can likewise be a hazard factor for brutality in psychosis, as attested by a current meta-examination (Witt et al., 2013). Witt et al. (2013) found a direct relationship between savagery (counting a scope of measures, for example, detailed hostility and captures) and adherence to medicine [odds proportion (OR) 2.0] based on nine investigations.

In suicide inquire about, adherence has been noted as the 'most grounded modifiable defensive factor' against suicide in patients with bipolar turmoil who were taken after for a long time(Lindstrom et al., 2012; Ugarte et al., 2012).

Misdrahi et al. (2012) broke down the post-mortem examination blood tests of 33 patients from a psychosis center who had submitted suicide over a 7-year time frame. They turned out with the discoveries that plasma tranquilize levels for recommended antipsychotic and stimulant solutions proposed that three out of 24 were non-disciple to antipsychotics and 10 out of 10 were non-follower to antidepressants at the season of their suicide. Additionally, Ruengorn et al. (2012) utilized a case– control procedure and assessed the chances of suicide endeavors in patients with real depressive issue as generally twice as high for patients with low adherence. Untimely mortality in schizophrenia (Cullen et al., 2013). reflectively analyzed the records of a companion of United conditions of America patients with schizophrenia and uncovered that low adherence to antipsychotics estimated mortality. Likewise, with existing examination demonstrating a connection amongst mortality and adherence(Simpson et al., 2006), it is not evident whether adherence in itself realize diminished mortality, or whether it is a marker for different components. For example, as indicated above, adherence could directly affect mental outcomes and related hazard. Be that as it may, adherence might be a marker for a more straightforward causal impact, for instance great social help or a propensity to participate in solid practices, including exercise, great nourishment.

## **2.4 Caregivers and caregiving**

A person who performs task for another person who is unable to independently perform those duties could be describe as a caregiver. Such care is provided either based on an employment agreement or other official arrangement or voluntarily (Goodhead & McDonald, 2007). The condition under which the care is given defines the caregiver as formal or informal. While informal caregivers are naturally supposed to show care for their family members/friend, the care meant here goes beyond normal expectations to include some allusion to unusual dependence by the recipient often because of a medical condition, such as schizophrenia (Hermanns & Mastel-smith, 2012). The responsibility of a caregiver, especially for caregivers of schizophrenic persons, comes along with it often excruciating burden in several shades, varying from physical and emotional stress, social stigma to socioeconomic costs. Caregiving for schizophrenic patients often include help with activities of daily living, ongoing monitoring, liaising with formal care systems, and attending to any shortfall not provided by paid health care workers among others (Goodhead & McDonald, 2007).

The World Health Organization estimates that globally, about 40% - 90% of patients with schizophrenia live with their families (WHO, 2008). On the other hand, recent changes in family structures and rapid economic decline in many developing countries are threatening such family support available to patients with chronic mental illness (Yusuf, Nuhu, & Akinbiyi, 2009). Veltman, Cameron and Stewart (2002) conducted a qualitative study looking at caregivers' perspectives on both the negative and positive aspects of caregiving. They conducted twenty in-depth, audiotaped, semi-structured interviews focusing on caregivers' positive and negative personal experiences of caregivers toward a relative with mental illness. Caregivers reported similar negative consequence but also useful effects, such as feelings of gratification, love and pride. They found common themes of stigma, systems issues, life lessons learned and love and caring for the ill relative. This study counterbalances

the frequently negative consequences initially reported and adds to the emerging literature on positive aspects of caregiving. The authors note that professionals need to help caregivers' families make choices to improve their demanding situations. They need to help caregivers identify the rewards of caregiving and to recommend for increased community support.

Andrews, Farhall, Ong & Waddell (2009) looked at the perceptions of mental health professionals and family caregivers and their collaborative relationship with one another. The study suggested that relatively simple collaboration models can describe routine Professional-caregiver interactions, although professionals possess a more differentiated concept of collaboration than family caregivers. Unexpectedly, both professionals and caregivers trended to attribute responsibility for collaboration to the other group. They recommended that training programs in which mental health professionals and caregivers jointly learn the best ways to work together. Psycho educational programs appear to help alleviate some of the sense of burden often felt by caregivers.

Grandon, Jenaro, and Lemos (2007) examined the sense of burden felt by primary caregivers of persons with schizophrenia who were outpatients and found that psychological education interventions were effective in making the family caregivers feel less burdened with their caregiving responsibilities. Their study of 101 schizophrenic outpatients and their caregivers found that higher frequencies of relapse combined with lower self-control attributed to the patient, a reduction in social interest, and less effective support were predictors of a high sense of burden in the caregiver. Relapse was more common in patients who were non-adherent with taking medications. The authors recommended psycho educational programs as a possible intervention modality for caregivers in this situation.

Lastly, Muhlbauer (2008) looked at caregiver perceptions and needs regarding symptom attenuation in severe and persistent mental illness. This qualitative study used the symbolic interaction paradigm of dramaturgical interviewing. There were 20 caregivers in the study who took part in one to two-hour semi-structured interviews. The study found that lack of understanding about negative symptom exhibition was an important issue for caregivers. It led to substantial participant misinterpretation of patients' behavior and resulted in a situation of increased anger and hostility. The author noted that although information about negative symptoms has not been a primary focus of psychological education, data from this study strongly support the need for its inclusion. The author also advocated clear and direct conversation and interaction with patients and caregivers when patients are not in severe psychotic distress on possible actions and needs for the caregiver. (Hermanns, & Mastel-Smith, 2012).

## **2.5 Theoretical model**

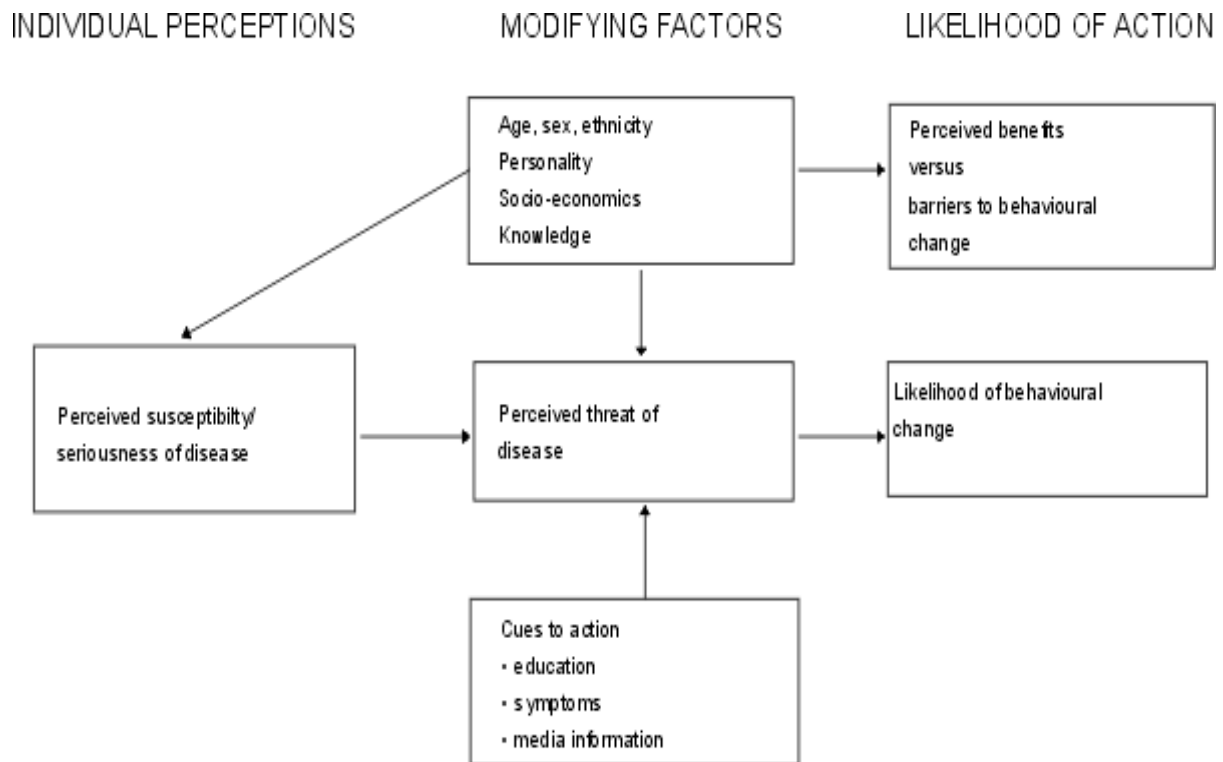
Khan (1999) postulates that a theoretical framework is a structure that can hold or support a theory of a research work. It presents the theory which explains why the problem under study exists. Thus, the theoretical framework is but a theory that serves as a basis for conducting research. The main theory that guided the study was The Health Belief Model. However, other theories such as the trans theoretical model and the precaution adoption model and the self-medication hypothesis complimented the Health Believe Model.

### **2.5.1 The health belief model**

The Health Belief Model (HBM) was developed in the 1950s and has been practiced because it is logical, well-articulated and simple. The Health Belief Model proposes that individual convictions and saw weakness, seriousness, advantages and hindrances all consolidate to decide wellbeing practices (Rosenstock, 1966). Helplessness alludes to the subjective

impression of individual defenselessness to a specific medical issue. Seriousness is the subjective view of seriousness or risk of a medical issue and its belongings. Advantages are the apparent adequacy of a scope of intercessions to treat the medical issue and obstructions are the apparent negative parts of a specific move made to decrease or wipe out the medical issue. These convictions are believed to be dictated by statistic factors and mental attributes. The model is most significant to the setting of embracing averting practices and halting unsafe practices.

Bosworth et al. (2008) survey found no proof that the wellbeing conviction demonstrate has prescient legitimacy in connection to medicine adherence. There are thinks about, in any case, which do propose a connection between measurements of the wellbeing conviction model and adherence in schizophrenia. Murray et al. (2012) and Budd et al (1996) found a relationship between convictions around helplessness and adherence status. That is, the individuals who adhered to drug apparent themselves to be more helpless to backslide than non-adherers. Adams & Scott (2000) announced that apparent seriousness of sickness and saw advantages of treatment clarified 43% of the variety in adherence conduct.



Source: Glanz et al, 2002, p. 52

### Favorite Methods

**Title: Conceptual framework showing perception, modifying factors and likelihood of action of patient at the Pantang hospital**

### Perceived Threat of Disease

The construct of perceived seriousness speaks to an individual's belief about the seriousness or severity of a disease (Salari & Filus, 2017). While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties a disease would create or the effects it would have on his or her life in general (McCormick, Brown, 1999).

### Perceived Susceptibility

Personal risk or susceptibility is one of the more powerful perceptions in prompting people to adopt healthier behaviors. The greater the perceived risk, the greater the likelihood of engaging in behaviors to decrease the risk (Salari & Filus, 2017).

### Perceived Benefits

The construct of perceived benefits is a person's opinion of the value or usefulness of a new behavior in decreasing the risk of developing a disease (Salari & Filus, 2017). People tend to adopt healthier behaviors when they believe the new behavior will decrease their chances of developing a disease.

### **Perceived Barriers**

Since change is not something that comes easily to most people, the last construct of the HBM addresses the issue of perceived barriers to change. This is an individual's own evaluation of the obstacles in the way of him or her adopting a new behavior (Salari & Filus, 2017). Of all the constructs, perceived barriers are the most significant in determining behavior change (Jam & Becker, 1984).

### **Cues to Action**

In addition to the four beliefs or perceptions and modifying variables, the HBM suggests that behavior is also influenced by cues to action. Cues to action are events, people, or things that move people to change their behavior. Examples include illness of a family member, media reports (Graham, 2002), mass media campaigns or health warning labels on a product (Ali, 2002).

## **2.5.2 The trans theoretical model and the precaution adoption model**

The Trans hypothetical and Precaution Adoption models characterize phases of conduct changes. The upkeep organize is just a single phase of these. The upside of these stages is in understanding that the phases of social change vary essentially. For instance, the variables that urge a patient to start to take after an endorsed conduct might be altogether different from those that empower keeping up the conduct in the long haul. These models attest that mediation to advance a conduct ought to be to the stage the individual is in.

### **2.5.3 The self-medication hypothesis**

The Self-Medication Hypothesis expresses that patients choose to begin, change or stop recommended medicine as person wellbeing needs and that such choice is led deliberately and objectively, given the data accessible to the patients and their comprehension of their condition (Mitchell & Selmes, 2007). Mitchell & Selmes (2007) states that there is confirmation that patients with a psychological maladjustment do hinder or stop medicine both deliberately and inadvertently, construct generally in light of how they are feeling, which incompletely underpins the self-solution speculation.

It is hard to survey these speculations in exact investigation. One noted shortfall of research of adherence in patients with psychological instability is that the formative procedure of choice identifying with prescription considering isn't taken (Marland & Cash, 2005). Elective ways to deal with downplaying prescription taking have been recommended. Demyttenaere (1997) talks about the pertinence of considering a medicinal brain research way to deal with comprehend why every individual patient, with his or her indications, social setting and restorative affiliation isn't disciple. Inside this approach, the hypothesis of imperatives makes the inquiry 'what compels this patient from all the more adequately dealing with his or her condition?' (Staring et al., 2011).

Weiden (2007) proposes a comparative approach in characterizing a more adaptable way to deal with adherence hypothesis that is more appropriate to clinical practice. He proposes five hypotheses in regard to medicine adherence in patients with schizophrenia. These are:

Adherence is certifiably not a clinical result and just issues as it meddles with result. Also, adherence issues are regularly ensnared with viability impediments of antipsychotic pharmaceuticals. Adherence can be seen as a conduct (taking/not taking) or as a state of mind (favors taking/inclines toward halting drug). When thinking about adherence states of mind,

quiet convictions are dependably reality, finally Adherence practices changes and varies after some time and ought to be thought about piece of the disease.

The equivocalness emerging from the use of these speculations can be represented by thinking about reactions to the third of these hypotheses. On the off chance that adherence is seen as a conduct, ways to deal with enhance adherence should address whatever strategic issues keep patients from taking their solutions as endorsed. Then again, if adherence is seen as a state of mind, their doctor must look for approaches to teach and persuade the patient of the advantages of their prescription. As depicted by Weiden, non-adherence to pharmaceutical in schizophrenia normally isn't both social and attitudinal.

The hypothetical models talked about set out to comprehend the components that clarify adherence-related practices. These cover a scope of disciple practices from safeguard practices to adherence amid the support period of treatment in incessant sicknesses and reactions to enhance adherence. These models have prompted fruitful methodologies, basically in the region of inspiring solid practices. In any case, these adjustments in practices are regularly not kept up. Models which additionally center around the understanding the conduct reactions to being in the upkeep period of endorsed pharmaceuticals in ceaseless sicknesses are required. Such models will energize the improvement of methodologies of interceding to counteract support stage non-adherence before it happens.

## CHAPTER THREE

### METHODOLOGY

#### 3.0 Introduction

This section focuses on the blueprint for the study and show how the research design, sampling procedure, target and study population, data sources, inclusion criteria, data collection procedure, data handling, analysis process, and ethical considerations were chosen.

#### 3.1 Study Design

This research used qualitative design with a phenomenological approach. This design was used because phenomenology searches for the meaning or essence of an experience rather than measurements or explanations (Giorgi, 2012). This branch of philosophy “describes the philosophical approach that what is directly perceived and felt is considered more reliable than explanations or interpretations in communication” (Remenyi, Williams, Money, & Swartz, 1998). Giorgi (2012) expands phenomenology beyond that of 'experience' and states as follows: 'In phenomenological research, it is the participants' perceptions, feelings, and lived experiences that are paramount and that are the object of study'. The design permitted the researcher to capture and understand the participants' different points of views on individual, institutional, community and pharmacological factors affecting medication non-adherence in mental health patients. The design sought meaning and understanding which was described in narrative form. According to Polit & Hungler, (1995) “qualitative design involves the systematic collection and analysis of subjective narrative materials using procedures in which there turns to be a minimum of researcher-imposed control. The design attempts to understand the entirety of some phenomenon rather than focus on specific concepts”. Also, Sandelowski, (2000) opine that “qualitative descriptive study also gives an inclusive summary of a phenomenon in day-to-day events with the intent of vivid validity and truthful accounts of actions”. The principal researcher explored the numerous views

caregivers have regarding factors affecting medication non-adherence in mental health patients.

### **3.2. Study Area**

The study was undertaken at the Pantang Psychiatric Hospital (PPH). PPH is a referral hospital in the La Nkwantanang Municipal Assembly of Greater Accra region. It is a 1,500-bed facility and attends to 1,000 to 1,200 outpatients every week. PPH has 399 mental health nurses, 2 psychiatrists, 11 medical officers, 3 clinical psychiatric officers, 8 physician assistance, 4 nurse practitioners and other supporting staff. PPH provides services to clients coming from all over the country and neighboring countries. The hospital is divided into several departments including; Occupational Therapy, Social Work and Clinical Psychology, Nursing, Catering, Accounts, Human Resource. Services accessible include; in- and outpatient psychiatry and general services, child and adolescent services and community services. The in-patient consists of: 3 acute wards, 2 rehabilitation wards and 3 chronic wards. Per day the hospital attends to about 67 patients and the department admits 3 patients a day.

### **3.3 Study Population**

According to Castillo (2009) targeted population refers to the collection of individuals or objects that are the focus of a scientific query, which suggest that target population is a group of people that is acknowledged as the intended recipient of a researcher. The population consisted of formal caregivers of mental health patients. (Mental health nurses, prescribers and informal caregivers (family members or friends)).

### **3.4 Selection Technique**

Twenty caregivers were purposively chosen from the Pantang Psychiatric Hospital (Out-patient Department and on the wards). The in-charge of the psycho OPD was informed about

the aims and procedures of the study and requested to aid in finding nurses, prescribers, and patients relatives for the in-depth interviews. Nurses from the various admission wards were selected with the assistance of the ward in-charges. Purposive sampling approach was chosen because it allows the researcher to deliberately choose the cases that will contribute to the information needed for the study (Polit, D. F., & Beck, 2010). Therefore, the researcher worked with caregivers of mental health patients who have had the condition for more than 6 months. Selection of care givers was done by recognizing informal care givers (patients' relatives or non-relative) who accompanied patient to the Psycho OPD for review, health workers (nurses and prescribers) who have been attending to mental health patients. Caregivers who met the inclusion criteria were chosen and the nature of the study was explained to them before asking for their consent. Informal caregivers who decided to participate were interviewed on the same day whereas the formal caregivers were scheduled based on their availability.

### **3.5 Inclusion criteria**

Caregivers were above 18 years of age and either related to the client or not and must have lived with the client for more than six months in the same household and often accompany the clients to the health facility. They also include caregivers (health workers) who have been attending to the clients in the past six months from the time the study was conducted.

### **3.6 Exclusion criteria**

The researcher excluded certain relative caregivers from taking part in the study. Thus, to be excluded as a relative caregiver one must be less than 18 years of age and must be a caregiver of new patients.

### **3.7 Data collection**

Some researchers explain that “interview is a managed verbal exchange” (Gillham, 2000; Ritchie & Lewis, 2003). Therefore, effectiveness of interviews depends heavily on the communication skills of the interviewer (Clough & Nutbrown, 2007). Some researchers indicate that the aim of the interviews is to acquire the individual perspectives of the interviewees (Flick, 2011). Interviews are a standout amongst the most vital source of data in research (Yin, 1994) that offer a researcher the chance to modify the line of inquiry, catch up on interesting reactions and research fundamental motives in a manner that posted and self-controlled questionnaires cannot, consequently upgrading the dependability of the information (Robson, 1993).

Interviewees are urged to talk straightforwardly, honestly and give however much detail as could be expected. More data and in more prominent profundity can be acquired through interviews. The Interview additionally permits flexibility as there is a chance to rebuild questions (Kothari, 2004). Data was collected within two weeks by principal researcher and a research assistant with background in qualitative research. Qualified participants were given full explanation of the study, and the importance of the study. They were also informed of the data collection procedures which involved audio recording of information given during the in-depth interviews (IDIs). In-depth interviews involve discussions with a small number of respondents to seek their views on a precise event, phenomenon, circumstances.(Boyce & Neale, 2006).

#### **3.7.1 Data Collection Instrument**

A semi-structured interview guide was used to seek participants’ views on the research topic. This was used because it directed the researcher and allowed participants to speak on other issues through probing during the discussion. The interview guide included information on participants’ socio-demographic data such as age, sex, marital status, occupational status,

educational level and relationship to client. Information on participants' perceptions on factors affecting medication non-adherence among mental health patients was also sought.

### **3.7.2 Data collection mode**

Participants who accepted to undertake the research were given a consent form to sign.

After winning the approval of the patients, the researcher created a rapport with the respondents to kick start the interview. The researcher permitted free expressions from interviewees and probe further for rich information. The one on one meeting went on for pretty nearly 45-60 minutes long to one hour for every member. The interviews took place during the free time of the respondents in their designated seating's in their various locations. This process helped established relationship between the participants and the researcher before the in-depth interviews. Interviews with nurses was conducted in the conference room of the Psycho OPD, prescribers, in their consulting rooms and patient's relatives at the corner of the pavilion at the OPD since they didn't want to miss their turn in the queue. IDIs was carried out to obtain evidence on participants' perceptions on factors affecting medication non-adherence among mental health patients.

To get singular view of members, parental figures were talked with, in a steady progression. All through the procedure of information accumulation patients' relatives were talked with to begin with, trailed by prescribers lastly the mental medical attendants. Data was collected from participants until saturation was achieved. Saturation was reached when the information gathered by the researcher did not provide new perception or understanding (DePoy & Gitlin, 2012). Interviews were conducted in English and Twi and collected through a digital audio recorder (with the consent of participants).

Demographic information, for example, educational level, your years of experience, job title, department of the of hospital, sex of the respondent, age of respondent were gathered. Be that as it may, no distinguishing data, for example, name, telephone number, or email was taken from respondents. Before the researcher conducts each interview, she would (Talbot, 1995):

1. Thank the employees for making the time and willing to be part of the study.
2. Remind the employees with regard to their promise
3. Explain that the interview will be unstructured and that question would be controlled by the data given by the respondents.
4. Sought their concern to tape record the interview.
5. After an interview, the researcher played back the recorded information to guarantee voice clarity.

### **3.8 Data Analysis**

Personal data of respondents was analyzed illustratively and put into tables. Documented interviews in Twi (the most spoken dialect in Ghana) were transliterated into English to write the report for this study. The primary researcher rechecked the exactness of the interpreted information by tuning in to the recorded interviews and redressing minor slipups. The interview transcripts were analyzed in totality, to get a general feeling of the substance of the reactions by the members to different issues. Every transcript was perused a few times to empower the analyst to draw in with the emerging information.

NVivo 14 version software was utilized to investigate the information. Translated information was first served in a word preparing program i.e. Microsoft Word. At that point the analyst imported the translated data (sources) into the software and analyzed

Each source was then coded to accumulate material into topics or hubs (classes). As the information is showing, a portion of the words or expressions which seemed significant were

featured and embedded into proper hubs. Reminders was made all through the investigation procedure as new bits of knowledge and thoughts rise. The thoughts were reviewed effortlessly as the reminders depict each code or hub.

Hubs were coded into sub-hubs to make a hub pecking order. Investigation of the information inside NVivo was done to make diagrams, and bunches. Group examination was utilized to distinguish sources or hubs that contain comparable ideas. In this investigation bunch examination was done to investigate hubs that will group with comparable codes.

### **3.9 Ethical considerations**

Several issues were considered under ethical considerations as follows:

First, ethical approval was sought from the ethical review committee of the Ghana Health Service. With protocol identification number GHS-ERC:025/02/18. Secondly, authorization and approval were also obtained from the research committee of Pantang Psychiatric Hospital before data was collected. Participants who agree to partake in the study were entreated to complete a printed informed consent form, and arrangements for an interview with each participant made. Participation was voluntarily, and participants had the freedom to withdraw at any time during the study. Further, to ensure confidentiality, code numbers were used for each participant instead of their names. One copy of the signed consent form was with the researcher, and a second copy given to the participant. And finally, privacy was maintained always during the interviews by conducting interviews in enclosed areas.

### **3.10 Quality Control**

A two - day training was organized for the research assistant by the principal researcher on how to conduct the interviews. He was taken through interviewing techniques and skills, administration of interview guide without coercion, note taking and recording. Also training

on handling of nonresponsive interviewees was done. The training also included language and translation of interview guide into local languages. On daily basis, the principal researcher ensured the collation of all recorded interviews. All recorded interviews, consent forms and interview guide were kept by the principal researcher and confidentiality ensured during the research process. The interviews were conducted in English and Twi. Interview guide was reviewed by my supervisor to ensure content validity. A field pre-test of the interview guide was conducted at the Accra Psychiatric hospital. After pre-testing a review of the interview guide was done accordingly.

## CHAPTER FOUR

### RESULTS

#### 4.0 Introduction

This chapter presents the findings of the qualitative data acquired for the study from the field. The analyses start with the background information of participants involved in the study, followed by participants understandings on What patients-related, factors affect medication non-adherence among mental health patients, what institutional factors affect medication non-adherence among mental health patients followed by what community factors affect medication non-adherence among mental health patients and ends with pharmacological factors affecting medication non-adherence.

#### 4.1 Background Characteristics of Participants

The demographic profile of the participants varied in relation to sex, age, relationship of the caregivers to the patient, level of qualification, and so on. Twenty caregivers of both genders were the subjects for this study. Fourteen were formal caregivers and six informal caregivers. The formal caregivers were eight registered nurses and six prescribers (3 medical officers, 2 clinical psychiatric officers and 1 physician assistant). Their ages ranged between 28 – 53, Out of the fourteen formal caregivers, six were females and eight males. It was reported that ten were married, three had never married and one divorced. In terms of educational status, all formal caregivers had tertiary education. The age range of informal caregivers was between 25 -67 with three females and three males. Three were married, two single and one divorced. Their educational background ranges from tertiary to middle form 4. Three of the informal caregivers had tertiary education, one reported to have had secondary education and two middle form four. Of the six informal caregivers, one is a student, one a lecturer, three traders and one retiree.

**Table 4.1: Demographic Profile of the Respondents**

Caregivers	AGE (YRS)	SEX	MARITAL STATUS	EDUCATIONAL STATUS	OCCUPATIONAL STATUS	R/N CPT
<b>Prescriber 1</b>	53	M	Married	Tertiary	CPO	Prescriber
<b>Prescriber 2</b>	34	F	divorced	Tertiary	PA	Prescriber
<b>Prescriber 3</b>	28	M	Married	Tertiary	Medical officer	Prescriber
<b>Prescriber 4</b>	33	F	Married	Tertiary	Medical officer	Prescriber
<b>Prescriber 5</b>	32	F	Married	Tertiary	Medical officer	Prescriber
<b>Prescriber 6</b>	40	M	Married	Tertiary	CPO	Prescriber
<b>Nurse</b>	47	M	Married	Tertiary	Nursing	Nurse
<b>Nurse</b>	32	M	Married	Tertiary	Nursing	Nurse
<b>Nurse</b>	36	M	single	Tertiary	Nursing	Nurse
<b>Nurse</b>	45	M	Married	Tertiary	Nursing	Nurse
<b>Nurse</b>	36	M	Single	Tertiary	Nursing	Nurse
<b>Nurse</b>	34	F	Married	Tertiary	Nursing	Nurse
<b>Nurse</b>	39	F	Married	diploma	Nursing	Nurse
<b>Nurse</b>	30	F	Single	Tertiary	Nursing	Nurse
<b>Relative 1 (family member)</b>	25	M	Single	Tertiary	Student	Nephew
<b>Relative 2 (family member)</b>	37	F	Married	Secondary	Trader	Niece
<b>Relative 3 (family member)</b>	67	F	widow	Mid 4	Retired	Mother
<b>Relative 4 (family member)</b>	56	F	Married	Mid 4	Trader	Mother
<b>Relative 5 (family member)</b>	34	M	Single	Tertiary	Trader	Nephew
<b>Relative 6 (family member)</b>	66	M	Married	Tertiary	Lecturer	Nephew

*Source: Field Data, 2018.*

A total of twenty (20) caregivers were interviewed.

#### **4.2 Patients-related factors and how it affects medication non-adherence among mental health patients**

Participant expressed various perceptions on the issues. Caregivers were probed on their health beliefs and religion, attitudes concerning effectiveness of treatment and lack of

motivation, previous experiences with pharmacological therapies, low socio-economic status, unemployment and inadequate nutrition and lack of insight, type of disorder, poor understanding of medication, and lack of involvement in decision making. Thus, this aspect of the presentation of findings or results addressed the issues one after the other and what respondents said as follows:

#### **4.2.1 Financial Challenges**

Moreover, financial challenges also emerged as one of the factors that affected medication non-adherence. In other words, according to the prescribers the patients find it difficult to get support to continue with their medications. The prescribers observed that some of the patient do not have the money for transportation to come for reviews. For example, a prescriber said;

*“Others too are mostly financial; money, where to get money, how to continue reviews, transportation, especially support, most of them are not working, and families too are not giving..... Some of them are not getting any form of this thing, support so continuing with medication becomes difficult so these are some of the problem” (Prescriber 2)*

*“.... The financial aspect is critical in their medication compliance. Someone taking lithium, sodium or bipolar is expensive, you spend GH 100 in two weeks or month. The moment you are bought here your access to finance is retracted., even if you are working. Am suggesting there should be an NGO to subside the cost mental health treatment....” (Nurse 2)*

To find out whether indeed cost had really prevented medication non-adherence, a relative of one of the patients who comes for reviews was asked to confirm this assertion by the nurse and prescribers and the findings showed that indeed this was the case as narrated below.

*“at first, when he was alone that was the reason why he stopped coming to this place, because he has to pay for everything and when he gets the money, he will go and spend it, he will not come here at all because he will tell you that he has to go and buy this, he has to go and buy that and he doesn't have the money so he will not come...” (Relative 2)*

#### 4.2.2 Distance

Closely related to the findings above is the distance from which some patients would have to travel to Pantang for reviews and medications. According to one relative distance has affected her ward in following up consistently for medications looking at the distance she has to travel coupled with the transport fares which makes it impossible for her to be consistent to following up for medications.

*“...we live in Aburi, distance also affect people from koforidua and because of monetary issues is not every month that they will be coming sometimes they elapse their months before coming it affect them and the sometimes the medicine will get finished and when they don't get the medicine it affects them one way or the other....”*  
**(Relative 1)**

Probing further the researcher found that for those who travel far to Pantang to seek mental health attention face the challenge of transport cost of travelling and to them this sometime does not make economic sense because according to one doctor the transportation in and out of Kumasi for instance is about twice the price of 2 months medication. For example, a prescriber said;

*“... a patient friend of mine left to Kumasi and when I want to know the reason why she was not reporting for review, it was because she doesn't have money. From Kumasi down here, the transportation in and out is about 2 times the price of 2 months medicine so when she gets the money to buy medicine for 3 months she only buys medicine for 1 month”* **(prescriber 1)**

Thus, travelling all the way from Kumasi, Aburi and Koforidua to Pantang consistently becomes impossible so most time they do not make it, and this has created some problem for the patients.

#### 4.2.3 Lack of Insight into condition

Furthermore, lack of insight into the patient conditions prevailed as one of the factors that affected medication non-adherence among patients. According to some of the prescribers the patient sometimes thinks they are well or better still do not believe they are unwell and hence

do not need to continue with their medication. This clearly shows the patients do not get it or they are not properly brief when it comes to issues of mental health. For example, a prescriber said;

*“so, one major factor is lack of insight into their condition a number of them don't think they are unwell. So, they don't know why they should be on medication. if they notice any side effect they feel that's the end of it. I shouldn't take the medication again” (Prescriber 3)*

*“Insight, if the patient doesn't know what exactly is wrong with her the person may not want to take medication” (Prescriber 4)*

A nurse confirmed this observation from the prescribers when she indicated that most patient will comply with medication when they are educated, brief or given insight as to why there is the need to adhere to their medication.

*“their compliance to the medication, one factor is when they know the reason why they are taking the medication. Most of them take the medication without knowing the reason” (Nurse 2)*

In addition to the confirmation above a relative of one of the patients also confirmed how formal caregivers had counsel his ward and for that matter he understand his condition and accept them.

*“...he has been counselled to understand and now he is being able to know that he is sick. He has admitted the fact that he is not well...” (Relative 1)*

Again, as we all know education has always been the bedrock for the very reasons we acted and reacted the way we do and therefore this finding exposed this deficiency among patients with mental health since they do not have enough education so that the patients can have enough choice of medicine to take. However, in the opinion of the researcher a mental health patient cannot be expected to be knowledgeable unless the condition in which he/she finds herself or himself is very mild, in this regard the doctors could be excuse with such suggestion. Thus, with severe mental illness it will be farfetched to postulate such reason why

patients are not heeding to their medications. Further, the finding shows consistent change of medication brand as factors that affect medication non-adherence.

#### 4.2.4 Family Influence

Still on factors that can affect medication non-adherence the study discovered that family influence is a factor. The doctors pointed out what they have observed and heard the patient discussed about these issues and according to the doctors this discussion point to the fact that families of these patients are a bad influence when it comes to encouraging mental health patient to adhere to prescribe medication.

*“sometimes influence from family. Once they feel they are fine, they don’t want to take the medication” (Prescriber 3)*

*“they don’t have support from home, sometimes if they don’t get support from family members they may not take their medication. (Prescriber 5)*

#### 4.2.5 Religious Beliefs

Also, religion has taken a toll on issues of medication and this is what a prescriber said on the matter

*Sometimes some religious beliefs as well, so they have some religious beliefs, that whatever is happening is spiritual so there is no need for them to take the medication” (Prescriber 3)*

*“In terms of religious believes, some could say that per their religion or the understanding of the condition they are suffering from, medication is not the answer rather it prayers that they can get their healing so in that case they are not likely to go by the medications as prescribed”. (Nurse 3)*

*“Yes. Some also believe it’s spiritual problem and not hospital issue. They prefer to visit churches and prayer camps and seek for help instead of taking medication. Some also believe that the medication will aggravate the illness. Some also believe that taking the medication make u act abnormal. That’s their believe so they do not adhere to the medication” (Nurse 6)*

Again, some nurses pointed out that some of the patients rejected medication based on their religious beliefs and think that medication is not the answer but rather prayers. It is obvious

from the findings that religion and spirituality has crept into mental hospitals influencing how patients relates and adhere to the medications.

#### 4.2.6 Superstition

Couple with the family influence and religious beliefs are the issue of superstition, hearsay and stigmatization. The study further found that some patients have been told a lot of scary incidences or better still been given scary information based on experiences of other patients with respect to the effect of the drugs and therefore have refused to take their medications. Besides, families of these patients also serve as a hindrance to taking of medications. This was confirmed by a prescriber.

*“And some of them have heard a lot of things around so they are scared of certain things happening to them when they take the medication. so, they will rather not take it” (Prescriber 3)*

Having looked at the religious belief from the perspective of prescribers or doctors, the nurses on the other hand also gave their perspectives on the issue of religious beliefs and its effects on medication non-adherence. Some were not aware of any particular religious beliefs of these patients while others were aware of such beliefs impacting on the medication non-adherence. Besides one nurse indicated that at the climax of the condition the patient himself or a relative tend to God for healing but after some few days they accept the situation as it is and then make U-turn to Pantang hospital

*“I don't know of any religious belief, but I know of some religions that believe in, but some religions do not believe in it”. (Nurse 1)*

*“Some tend to be religious believing that God will heal them, normally it happens in the first to two days then afterwards if they recovery from the medication they accept the situation”. (Nurse 2)*

However, this nurse further added that some of the patients get advice from religious leaders or pastors not to adhere to their medication. Instead some of the patient use herbal concoction and rejects the orthodox medicine based on the advice patient have received and sometimes

they are directed to just fast and pray. Thus, as one of the nurses remarked “*that’s an indication that when they are discharged they will not take the medication at home*”.

*“others perhaps get advice from religious leaders or pastors. A pastor could say take either concoction or just pray and fast, so they don’t really need medication. Others will also say that medication comes from plant, so instead of taking white man’s medicine he or she will prefer taking the local preparation” (Nurse 3)*

*“Yes, I happen to be in the ward, some religious believers prefer to be taking their own concoctions while on admission. So, they don’t even believe in the medication you are giving to them. That’s an indication that when they are discharged they will not take the medication at home” (Nurse 5)*

Giving an interesting experience nurse 5 shared an experience she had and said that she “was at the ward when some Muslims came, they were requesting to take the patient home to see a traditionalist. Their trust in their religious believe influence medication non -adherence

On the other hand, almost all the relative interviewed did not express or better still gave a hint as to whether religion have impact on the medication non-adherence of the wards who are suffering from mental illness of some sort.

Consequently, from the doctors or prescriber’s and nurse’s perspective result on the factors that affect medication non-adherence by mental health patient were identified to be side effect of medication, harmful effect of the drugs, financial challenges, lack of insight into health condition, Education and Medication brand, family influence, religious beliefs, superstition, hearsay and stigmatization.

#### **4.2.7 Stigmatization**

Finally, there is also the problem stigmatization. That is the stigma associated with being a mental health patient and this is what prescriber 5 had to say on the issues.

*And stigma, because of the stigma associated with mental illness people will not want to take it for others to see that they are taking medicine. And then people also have*

*the perception that once you start taking medication from a mental facility then you will be a mental health patient forever” (Prescriber 5)*

#### **4.2.8 Health Beliefs and Religion**

As already indicated the researcher probed the health and religious belief of the respondents starting with that of the doctors and nurses and contracting it with the perspective of the relatives. As a result of this the doctors or prescribers were asked whether religious beliefs or health beliefs can influence non-adherence to medication and the responses shows that indeed religious belief appears to form the central reason why most patients refused to adhere to their medications.

The doctors or prescribers answered in the affirmative as to whether Religious belief has some influence or affect medication non-adherence. In their confirmatory responses they indicated that most of the time it’s the parents of these patients that tow the religious line and say things like *‘there is something more spiritual to the illness’*.

*“Religious belief yeah, the only religious is that sometimes when the person is coming here, either the patient themselves or their relatives believe that there is something more spiritual to the illness” (Prescriber1)*

*“Yes, yes a lot, like the last but one case I saw, there is a pastor when they come here we give them medication as to treatment modalities and we tell them the nature of the condition, relatives become anxious, they want something to be done by magic, they want total cure, so they try seeking for spiritual intervention most often traditional intervention” (Prescriber 2)*

Furthermore, the doctors or prescribers indicated that some parents of these patients reject their form of medication and fall for spiritual and traditional treatment as indicated below.

*“Others too they reject this form of treatment and concentrate on spiritual and herbal form of treatment but till they go, and things worsen that is when they get back” (Prescriber 2)*

Again, it was revealed that some mental health patient’s religious belief does not allow them to even accept the medication or treatment from the doctors or prescriber at all. The question that then arises is that if the patients knows he/she will reject entirely the medication from the

prescribers or doctors, why would they then visit the hospital in the first place to seek for medical attention.

*“some people’s religion does not allow them to take medicine at all. Some also believe that they have superseding power that takes care of them” (Prescriber3)*

*“some religions may also ask the patient not to take the medication given and that their problem is a spiritual one. And then most of them have stop taking the medication suddenly” (Prescriber 5)*

This respondent added that some patients who agree to take medication would only do that with certain kind of religious invocation or prayers attached to it before they will take the medicine and even with that they still will not go for the full dose of the medicine prescribed.

For instance, some of them have

*“some will take the medicine with continuous religious practices but then will take lower doses than usual because they believe that they are getting the proper care from their religious father and heads, so you give them the medicine but then they wouldn’t take. That is what I have noticed” (Prescriber 3)*

Again, this respondent further said sometimes patients take their medication to prayer camps and at the prayer camp they are told to fast which eventually take them off their medication and inevitably affect adherence.

*“often people may come in here take the medication and go to prayer camps. usually it is the family that end up taking them there. And when they are there, they are told to fast for some time and are taken off treatment. So is part of the things that affects adherence. But often this information is kept from prescribers” (Prescriber 4)*

In a nutshell, religion has impacted negatively on patient non-adherence of medication they receive at the Pantang mental health hospital and it’s imperative that strict policies are design to manage the occurrence of such situation as revealed above.

#### **4.2.9 Type of disorder, poor understanding of medication, and lack of involvement in decision making**

On this score the doctors or prescribers indicated that lack of insight, type of disorder, poor understanding of medication, and lack of involvement in decision making can affect adherence to medication,

*“It can also affect adherence to medication, cause if the patient is involved in the planning and also is well-educated on some of this medication they should be able to comply. But in situation where the prescription is just issued out, you go to the pharmacy to get the medication and continue taking it without any.... the patient will not understand why he should be on medication” (Prescriber 4)*

Further, one of the relatives thinks that enough education on how a patient should take his/her medication will help his intake of medication.

*“.... It’s very important when you educate them on their illness they become aware of it and it helps them to take the medicine....” (Relative 3)*

#### **4.2.10 Forgetfulness**

Moreover, a relative revealed that her ward’s non-adherence to medication was because of mere forgetfulness. However, with prompting he will adhere to the medication.

*: “...sometimes its forgetfulness, he just forgets about it and be there. Unless you prompt him to take it then he would take it before he does it....” (Relative 1)*

*“...in terms of the frequency, especially with the orals, people actually tell you they forgot to take....” (Nurse 3)*

### **4.3 Institutional Factors Affect Medication Non-Adherence in Mental Health Patients**

The study further probes institutional factor that affect medication non-adherence in mental health patients. This section focusses on two institutional factors such as the cost of care of medication and admission and attitude of health workers as well as ineffective communication

#### 4.3.1 Cost of Care (Cost of Medication, Cost of Admission)

On the cost of care (Cost of Medication, Cost of Admission) a doctor or prescriber revealed that the price of medication and care is also escalating which is throwing mental health patient back onto the street and their home. For instance, this particular doctor gave an example of what somebody on Haldol D 100 mg will spend on daily basis which is almost 100 cedis as indicated below

*“the prices of medication and care now is just escalating now; the prices of the medicine are throwing them out. Somebody on Haldol D 100 mg is almost 100 cedis. so, can you just imagine every 1month and that person, the medicine alone is taking 100, transportation and maybe what the person will eat will take about 40 cedis. 140 cedis every month and that person is not contributing one cedis to the family coffers” (prescriber 1)*

Another prescriber also indicated that the distance or accessibility to health facilities and cost of care deter a patient from taking his/her medication. This prescriber added that because patient these days pay their own medication couple with the fact that the medication is expensive also affect adherence to medication.

*“For now, most of the patient buy their own medication, the medication is expensive. In situation where there is no support be it social and financial, in addition to that, the patient resides far away from the facility it would be difficult to take care of all this thing. Arranging for money to buy the medication is a problem, and here is the case there is additional cost of transportation” (prescriber 1)*

*“So, distance and accessibility. So, we can look at the two together, because the person will be covering a long distance, if the place is not readily accessible. So currently if you need long term admission, you have to travel all the way from the north to the south because all the hospitals are here. And besides the distance you are covering, every other thing increases. transportation. the cost that somebody will incur down here, will be much less than your own because transportation in and out is not part of it...” (Nurse 3)*

The above finding was also confirmed by a nurse who showed that the number one factor that hampers medication non-adherence is the cost of treatment. According to this nurse the

patient would have to pay for everything from medication to even accommodation and feeding. For example, some nurses said;

*“number one that comes to mind will have to be cost of treatment. Because it appears to be more expensive to be mentally ill than physically ill. Because you are paying for everything, from medication to even accommodation and feeding” (Nurse 6)*

*The health system factors cost is key. So, most of them are not coming because they don't have the money to buy the medication” (Nurse 6).*

On the other hand, the doctors or the prescribers were asked to tell whether the health system available hinders adherence to medication. The responses show that the nature of health system particularly with respect to mental health is such that it does not allow close monitoring of patient. Further some doctors indicate that the current health system makes it very difficult for patient to go for review especially when the patient is coming from a distance like Tamale and so on. This is what some of the doctors had to say:

*“yes, patient from Narulugu who stayed for about 3 months after he was discharge home and we send the person to Tamale and asked him to come for follow up or review. Due to distance he could not. So, if the health service is closer to the person that the person has to walk or spend some few cedis and he is there its easy but me that am ok why should I even travel from that place tamale to Accra to come for medicine (Prescriber 1)*

Again, the cost of drugs, cost of basic lab investigations, cost of liquid profile has made the health system very difficult to access and so hampers adherence. Others also strongly pointed out that some mental health patient will not access Pantang mental health hospital because of the mere fact that the place has been branded for people with mental illness. This according to one doctor puts patient off outrightly.

*“they are expensive in addition to the cost of medication that they have to buy. So, these are some of the things at the health facility that stops them from coming if you ask them” (Prescriber 2)*

*“Just by the mere mention of psychiatry hospital. So, they wouldn't want to come for medications” (Prescriber 3)*

*“Yes, one is stigmatization, mental health on the whole is stigmatize. So sometimes coming to the hospital, having people know that you are coming here is an issue”*  
**(Prescriber 4)**

To confirm the issue of cost one relative told how much she spent in the past and compared it to the present cost to demonstrate how cost has become a problem to relatives and their wards thereby affecting medication non-adherence. In fact, this relative gave a chronology of the process she has to go through couple with the amount she spent at step of the process. This is what she had to say;

*“..... initially, we were bringing a hundred cedis but now we bring a hundred and eighty or sometimes two hundred. With the transportation and everything, we come to pay consultation fee 15 cedis. When the sugar level is checked, you pay four cedis but now, there has been a rise, so it is a hundred cedis. She is even saying I have to pay 15 cedis but since I am already complaining about money, I should bring the 10 cedis. You see, it depends. Sometimes, we take the medicine for one month. When I check my monies and I can afford two months, I also take it.....”*(Relative 3)

Another, health system factors that emerged from the results of the interview was the inability of the health workers to adequately provide patient with the requisite knowledge on issues of mental health and the process involved in diagnosing the situation that brought them to the hospital and why they should be serious with medication.

*“Yes, health system factors may be one or two. Talk about health workers inability to educate the patient, one on the diagnosis and why they should take the medication.”*  
**(Prescriber 4)**

From the findings these emerged as health system factors that might prevent the smooth adherence of medication.

#### 4.3.2 Attitude of Health Workers, Ineffective Communication

Furthermore, the attributes of health workers and poor ineffective communication could be a factor that hinders adherence to medication and in view of this respondents were asked if this is the case on the ground and the following constitute their responses.

*“.....a man from Asamankese always want to see me and no one else. Because one day he came, and somebody gave him chlorphenazine and went to inject and the guy had reaction and was very, very bad so this time when he come she wants to see me at all cost. If I am not around and he comes, and they have to write the medicine for him he has to snap it and what’s up me to make sure that it’s the right medicine. So, our attitude yes seriously hmm” (prescriber 1)*

*“you see the lady who just left here, Yes, she knows that every nonsense she can tell me even though he has been seen by another prescriber. But she just wants to be sure is the right medicine. So, our attitude counts a lot” (prescriber 1)*

From the responses it appears the patients who visited Pantang have their choice of medical practitioners they prefer to consult because of the experiences they have had with other practitioners as narrated by the doctor above. In other words, the treatment given them previously had bad impression on them and for that matter would not want to consult any other staff unless the ones they are familiar with. Therefore, some of the patients picked and choose who attends to them.

Nevertheless, some of the doctor did not find any bad attitude among the staff and rated the staff attitude and communicated as fair. In fact, to this respondent they (prescribers) do not stigmatize the patients but rather they try and understand the situations these patients found themselves and approached them with a better explanation of the situations.

*... in general, it is fair. We try to, we understand the condition and when they come is we they rely on for treatment so for us looking down, stigmatizing them is a no, no, for me. We try to understand their situation and explain things to them. For negative attitude on our part as health care that one is a no, no, from the angle of prescribers (prescriber 2)*

Others also said they have had complains about the bad attitude shown to some patient by the staff of the hospital as shown below.

*“...and some also complain about attitude from staff also so part of it aside that I don't see anything that should deter them” (Prescriber 3)*

Furthermore, the results from the interview gathered showed how some of the doctors or prescribers virtually agreed to the fact that communication mechanism used to convey patient health information is very key in preventing non-adherence to medication. Others also believe that poor manifestation of attitudes towards patients could also prevent non-adherence to medication. The following constitute what some of them said.

*“I believe that attitude of the health worker, relatives can affect adherence to medication. So, if they get the impression that you were not caring enough, the language you use was not good, you talk harshly to them, you didn't explain properly, or a patient came around aggressive the way the patient was attended to at a time was not pleasant enough it can affect the way the patient will take their medication” (prescriber 4)*

On this very issue another prescriber remarked that “the patient needs to be motivated to understand the need to continue taking the medication and then they should be motivated in such a way that by taking his medication, his's going to be well and he can also take part in any activity and work like any other person.

Again, one nurse agreed that attitude of Health Workers and Ineffective Communication could deter patients from accessing health facilities in general and she shared an experience she had when serving at Koforidua in the Eastern Region.

*“yes in the Eastern Region during a review one person did not come for review for a very long period of time, an old man who was hypertensive , when he came I was at the OPD checking the vitals and the man told me that the nurse told him that he likes coming to the hospital too much, every little thing he will come to the hospital so because of that when he is sick he finds it very difficult to come to the hospital and that's one example. (Nurse 5)*

However, according to this nurse ever since she started working at Pantang hospital such incidence has not happened in her presence. However, what she has notice is that some patient pick and choose who should attend to them and this is due to series of previous experiences. Thus, generally attitudes and communication are somehow better.

*“even here our attitude towards the clients is somehow better or good when you put it that way. some are doing well, others are also not doing well and because of that if clients have some specific staffs when they come around and don’t see those staff, they feel uncomfortable. even when we were in the ward there were some clients who liked us and were always asking us questions and that shows that our attitude can also prevent them from coming” (Nurse 5)*

*“Somebody was coming from Kumasi for review here and komfo Anokye is there, but the person said that no when he comes the way I talk to her she does not want to see anybody again” (prescriber 1)*

Also, a relative indicated that she has never encountered bad attitudes and ineffective communication from the doctors or prescribers and nurses. This relative even narrated an incident she witnessed and how the nurses handled the patient with care when he aggressively reacted and to him this was great.

*Ever since I started coming with him I haven’t seen any reaction from the nurses or the doctors that put humanity away. I quiet remember I notice this patient who was very much aggressive, the way they treated him was a bit encouraging for me. It tells me that mental illness doesn’t mean when you come here they have to treat you bad or something, they have a special way of treating their patient, so I acknowledge that. (Relative 1)*

#### **4.3.3 Non-availability of the medication**

Another astonishing revelation that emerged was the fact that medication sometimes becomes scarce or unavailable and this affects non-adherence. this is because when this continue it create intermittent use of the prescribed drugs and coming back to use it again when it is available becomes a problem for the patients.

*Non-availability of the medication is a problem. At the time the patient needs the medication and it is not available, so today he gets some money to come the next*

*moment he does not have so he won't come. then it becomes a problem, so this may end up in a discontinuation of the medication. (Nurse 5)*

#### **4.4 Community Factors Affect Medication Non-Adherence in Mental Health Patients**

Again, this section of the analysis reports on the community factors that affect medication non-adherence in mental health patients. Thus, issues such as stigma and its effect and other matters that emerges would be discuss here.

Accordingly, what emerged from the data was that stigma had some negative effect on mental health patients leading to their refusal to heed to medication prescribed for them. In fact, a doctor narrated an incident with a patient of his experience with her husband and indicated that this patient tried to hide her medication from her husband mainly because of stigma. This is what he had to say on that.

*“Because of stigma, one lady was married she is a teacher from kasoia when she was taking the medicine she was fine, and she said when I am taking the medicine and my husband get to know it, he will ask why I have been taking medicine every day and would want to know what it's meant for? and you know our people they will brand you, so she stops taking the medicine and she relapsed and it was the same husband who brought her. when she came I had the chance to talk to the husband and this time is the husband that brings her for review and she has not relapsed so our community stigma. it's because of stigma she was hiding the man” (prescriber 1)*

However, a follow up question which inquired from this particular doctor whether community factors could affect medication adherence in mental health patients positively. This doctor's answer was that it depends on the patients and their level of insight he or she has about the condition he found him or herself. This is what he had to say on this community subject;

*“when the person has good insight then I tell my patient that, patient plus medicine is equal to normal life” (prescriber 1)*

Probing further on the subject of community stigmatization some prescribers and some nurses were asked whether they think there are any community factors that can influence non-adherence and the following constitute their responses.

*“yes because of the side effect of the medicine. some of them the medicine affects their movement, then somebody ask and get to know that this is the thing” (prescriber 1)*

*“yes the moment you start taking the medications it slows your movement the effects people will start noticing that for instance why is he putting on weight and other side effects they might notice that something is wrong. So maybe if you are with your friends and you take the medications and you sleep more they might realize that there is something wrong” (Nurse 2)*

From this response it appears the side effect of the medication, which distort the movement or walking of mental health patients create or attract stigma from the community. This is because members of the community may observe certain unusual changes in your being and that will instigate interest and when members of the community find out then the stigma starts. In this view, this prescriber gave an instance that happened with one of his patients and this is what he had to say on this

*“there is one lady one of my clients, she asked me. they said when I am walking then am holding the right hand so when she came she asked, ha! Doctor can the medicine affect my hands I said yes. so, he told the friend that she is taking medicine and its affecting her. so, the friend told her to stop taking the medicine, can't you see you are growing too fat so the, community is affecting her negatively in the sense that that person should have tried to know the cost of stopping the medicine has it not being the lady is with me she would have stopped taking the medicine because people are talking about it. And not only one person telling her, then she stops taking the medicine, before we are aware she has relapsed” (prescriber 1)*

Others further said that the community still lacks knowledge on the subject matter of mental health illness and for that matter they find it very different to appreciate people with such conditions. To the extent that sometimes we hear people in the community as a way of getting mental health patients to be calm makes statements like if you don't behave well we will bring you to the mental health hospital.

*“yes, community level, you see people still don’t understand the nature of the illness that clients have. So usually they tend to stigmatize them. Even once they have a bizarre behavior and they say they are bringing you to psychiatric hospital, then people in your house right from your family, they begin to stigmatize you. (prescriber 2)*

According to this doctor sometimes words such as *eeii woyare no* (you have lost it) are use on this mental health patients at home and the community they find themselves and this discouraged them from coming to the hospital for review.

*“even issues that you have a say in it, when you alone say, they tend to say eeii woyare no o woyare no o So, these things right from the family level, our basic level has effects on....., so often when they are told to come for review because they don’t want to get themselves associated with the mental illness, they end up refusing the review sections and utility of care” (prescriber 2)*

Another intriguing stigma discovered is according to the doctors, the fear of being seen taking medication from a psychiatric hospital by other people in the community because of the fear of being tag wrongly. This make mental health patient retreat from taking their medications

*“one major factor is stigma, err they wouldn’t like to be seen taking medication from a psychiatric hospital. Because of the way people will tag them. So, they will rather not take the medication it” (prescriber 3)*

This prescriber also added that the settings of the environment in which the mental health patient finds him or herself attract community stigmatization and this discourage them from adhering to their medication. Thus, the setting here is the unsupportive nature of the environment both inside and outside of the home. With the home the prescribers have learnt that most family ask mental health patients to dump their medication and in place of that they ask them to follow them to church.

*“sometimes the setting also. You are in a certain area, with strong belief, even when you are willing to take it, the people around are not even supportive you enough when it comes to taking your medication. When you come home they will let you dump it, rather let’s go to church (prescriber 3)*

Therefore, if the environment is not enabling enough to support the fact that you have a problem and need to be on medication, it could also play a role. And then in the community, for someone to supervise you to take your medication is an issue.

To confirm the subject of stigmatization from the community and families of the patients on how it affects medication non-adherence, the researcher sought the opinion of the nurses in this regard and this is what they had to say.

*“.... with community factors, stigma is more of a positive factor to the patient because, the more you have a mental breakdown the patient in question already isolate because of the known thing with all of us as Africans. That alone pushes the fellow as well as relatives to quickly come to the facility to seek for medical care so that the patient will recover quickly and be able to fit back. So, it is in the positive direction, even though that name he is mad will still be there. but that will not deter the fellow from not complying with his medication. Because the fellow will try to comply in order to do well and fit. That is what I think not that because people are saying you are mad therefore you won't take your medication. And you even end up disgracing yourself...” (Nurse 3)*

From the response, this nurse rather gave different view of community stigmatization and looked at the issue from a positive angle without indicating that whether it affected medication non-adherence. This nurse rather rationalized the stigmatization argument and postulated that its rather positive because that will push the patient to ran for attention for the stigma to end.

#### **4.5 Pharmacological factors affect medication non-adherence**

Pharmacological factors which are the side effects of the medication and other issues affect medication non-adherence. In view of this respondents were asked to tell whether there are any pharmacological factors that can also affect medication non-adherence. In their response this prescriber set the premises for this discussion by saying that as long as we live we will be taking medicine un-end and therefore said that the frequent on and off of patients regarding their medication creates the side effect.

*“that also create more problems because the more the person take a high dose the higher risk of extra pyramidal side effect and then the worse of all the person will have tardive dyskinesia” (prescriber 1)*

Further, it is inevitable that majority of the patients who visit Pantang hospital to seek medical attention on mental health condition will have to be on medication for a longer period or perhaps the rest of their lives. This situation is of cause not a very comfortable situation and therefore according to the finding’s patients may forget somewhere along the line to take their medications. Thus, failure to comply with daily dose of medication may bring about the side effect as well as excessive intake of the medication.

*“chances are that, they may forget, so the compliance issue comes in. I think some of our medications we are trying to move them to the depo medication, once a month injection. It’s a bit more convenient for the patient” (prescriber 3)*

Other doctors also indicated the pharmacological factors that affect medication non-adherence of mental health patient. Among some of the effect they mentioned are restless, tardive dyskinesia, Parkinsonism and these has really affected non-adherence of medication

*“some patients take the medicine and will experience some side effects. Some effects associated with antipsychotic medicines are restless, tardive dyskinesia, Parkinsonism. So, and once the patient experiences this side effect, they may not adhere to it” (prescriber 3)*

In addition, the respondents hinted that if the patients are not educated in the consulting room before they leave the hospital premises it makes the entire process complex such that experience with that medicine becomes very difficult for them to go back

*“especially if they are not educated in the consulting room before they leave. Then the experience with that medicine becomes very difficult for them to go back. So, it is better we advise them, or we tell them that you go ahead and take the medication” (prescriber 4)*

#### 4.5.1 Side Effect of Medication

Thus, the interview began with the question ‘what are some of the patient- related factors that can affect medication non-adherence’? The responses show the views of the prescribers on the subject. According to the prescribers the first factor that affect medication non-adherence is that the patient complains of the side effect of medication (efficacy of drugs). This leads to patient’s refusal to take their medication because in the patient protest the drugs cause excessive drowsiness thereby making them feel very weak.

*“Sometimes they refuse to take the medication; they refuse that because of drowsiness, side effects of the medication. Especially they complain of excessive drowsiness, because of drowsiness they become weak and cannot do anything that is what they tell me” (Prescriber 2)*

Also, according to one of the nurses the feelings patient experience when they take this medication is one of the reasons why patient may not adhere to medication as evidence below.

*“In my view, side effects of the medication prevent them from taking the medication. Some of them don’t like the feeling they go through hence they don’t want to take it” (Nurse 5)*

#### 4.5.2 Fear of Harmful Effect of The Drugs

Furthermore, fear of the harmful effect of the drugs affected patient medication non-adherence. In fact, according to the doctor’s and nurses’ patients sometimes expresses apprehension on the side effect of the drugs which will not only cause drowsiness, difficulty controlling the tongues, skin rashes, drooling of saliva, twisted neck and make them weak but rather the medication will harm them as well.

*“Others feel the side effects will harm them more, others too feel they have been taking the medication for a very long time so why should he or she continue to take that medication” (Prescriber 2)*

*“Some of them have difficulty controlling the tongues; some have skin rashes and others, dizziness. Even when you don’t want to sleep, you are compelled to sleep” (Nurse 5)*

*Ok. I think most of them it's because of the side effect of the medication. It is very unpleasant; sometimes your tongue will come out, drooling of saliva and twisted neck. It's so uncomfortable. So, some of them that is the reason. Some also claim they are very hungry when they take the medication. They eat a lot and they also put on too much weight. (Nurse 6)*

In other words, the sides effect of these medication is so uncomfortable that most psychiatric patient would ignore taking them.

#### **4.5.3 Length of Time of Taking the Medication**

Besides, on the nurse's perception, in addition to what the doctors observed in relation to family influence and length of time of taking the medication is the sources of bad family influence. In fact, the results or data suggested that when the wards of this relatives have taken the prescribe medication for a very long time, they tend to be very concerned and on the bases of that stop their wards from continuing with the medication.

*“the length of time of taking the medication. Just recently the relative of a patient was saying that he won't allow the patient to continue taking the medication because he thinks that the patient has recovered and so one of the things they talk about is issues of well, the person has fully recovered so why the need for continuous medication. So, this is from the relative's aspect, even though the patient is willing to take the medication, the relative will be preventing him\her from doing so” (Nurse 6)*

#### **4.5.4 Type of medication, side effect of medication, frequency of medication, number of medications taken.**

Inquiring further, the researcher enquires from the respondents and in this case the caregivers whether the type of medication, side effect of medication, frequency of medication, number of medications taken affects medication non-adherence. The responses showed that to some extent frequency of medication or the number of times patient takes his or her medication affects medication non-adherence.

#### 4.5.4.1 Number of Medications

Thus, the relatives answered the question as to whether the number of medications their ward has to take in a day does put them off or probably complain that these medicines are too many, so they will decide to take it as and when he or she want.

*“...Sometimes he gets angry (Relative 2)*

In other words, the number of medications get this patient really angry sometimes according to this relative

#### 4.5.4.2 Frequency of Medication

Furthermore, the daily intake of medication is also a reason patient do not adhere to their medication which parents of relatives have to grapple with most of the time in helping or making sure that their wards adhere to the prescribed medications. Thus, one of the relatives said that, her ward complains such as the one below.

*“.... But yesterday I took medicine why am I taking today, I won't take them. You have to counsel him again and he will take it....” (Relative 2)*

#### 4.5.4.3 Type of Medication

Again, the type of medication could also create a situation for non-adherence especially when a new brand of the medication is given in place of a usual one. In fact, this nurse gave a typical instance of this particular issue as follows.

*“.....well the patient who have taken Largatil before and also taking the new brand now will be able to testify but we just see what we see but by far there are some who as at today the atypical does not work for them so they are on the typical so what about that but the majority falls within the atypical so if the person is an old client and used to take the Largatil for years and changes medication, the person will be able to identify the difference but if you do not find anyone like that you may not be able to access this information though it may be that pharmacologically and medically the ATPICAL ones are better than the typical ones with the psycho pharmacological side effects.....” (Nurse 1)*

From the response above it appears that the patient system could not respond to the same Largatil which is new compared to the old Largatil which he was used to. Well this could be better explained by a medical doctor, therefore for the researcher lay man's views the patient system does not simply adjust to the new Largatil.

However, one nurse remark on this issue that it "*is the right one that keeps their symptoms at bay and does not give them side effects. Then really the type of medication shouldn't be a problem.*". in other words, the right medication will keep their symptoms at bay and this speak for the observation of the nurse above, thus, this suggest that the prescribers and the patient must relate in prescribing medication such the doctor will do a follow up on the patients to find out the effect of the drugs on the patient after some period of medication. This will help to know which drugs is aligning with the patient systems and which is not to encourage adherence.

#### **4.6 Strategies Put in Place**

Finally, the researcher sought out for strategies from the respondents regarding what they have complained, lamented or observed about issues relating to caregiving at Pantang hospital. These strategies are as follows:

##### **4.6.1 Persuasion and Being Nice**

Among the strategies realized from the responses were persuasion of patients on their illness and what the medication will help do, therefore persuasion and being nice to the patient really help them to adhere to their medications.

*Me like I have to persuade him sometimes I have to talk to him in a nice way.  
(Relative 3)*

#### 4.6.2 One on One Consultation

Another nurse indicates the strategy she uses is one on one consultation with the patient to address issues like cost and side effect of the medication and this according is what she does to get them to adhere to medication.

***NURSE 6:** It's very important to have one on one consultation with patient. When you relax, they don't take the medication, find out the reason. Aside the insight that might take longer period. Other factors should be addressed individually, like reduction of cost and others like side effect.*

#### 4.6.3 Simple equation plan (client name plus medicine)

Again, a prescriber said he uses Simple equation formula to get the patients to adhere to their medication as indicated below.

*That is what I said from the beginning that I have a simple equation, but I will mention your name Mary plus medicine is equal to normal life. Because everyone has what he or she does to live a normal life. So, when you educate the client and the client has got insight and they know that this is what I do to have a normal life why not, they carry on because the person might have relapse because of noncompliance one or two times and a lesson is learnt (**Prescriber 1**)*

#### 4.6.4 A stop to stigmatization

Moreover, a prescriber advocated that there should be a stop on stigmatization of patient with mental illness because patients tends to run away anytime a mental health service is around. The caregiver suggested that mental health should not be limited to a particular place because chances are that it will deter people from accessing it.

*".... stigma, me the whole thing as I have seen is about the stigma. Because when the mental health service is at the environmental area that the patient lives, when the patient has the condition that is the place the person will be taken. now everybody knows that facility, that is what they do there...." (**prescriber 1**)*

#### 4.6.5 Education on their Condition

Educating mental health patients on their condition will get them to adhere to their medication according to this doctor and therefore suggested that mental health patient and

their families be education properly on the issue. In addition to this, prescriber 3 emphasis that the education must be psycho based

*“....so erm the first thing is as much as possible we educate them on their condition. One is to educate the patient and family on the condition....” (prescriber 3)*

*“....to psycho-educate patient in the consulting room, explain their diagnosis to them get family involve in the management of the patient and have a way of relating to the patient, establishing good rapport, letting the patient have that trust with us. So that they can continue the care....” (prescriber 5)*

#### **4.6.6 Dealing with Cost**

Finally, another prescriber said to get patient to comply with the medication means the cost element in mental health medication must be dealt with.

*“.... Patient compliance means you have to deal with cost, you have to deal with reasons why they are taking the medication, we also have....” (Prescriber 3)*

## **CHAPTER FIVE**

### **DISCUSSIONS**

#### **5.0 Introduction**

The discussion of the findings of this study is based on the themes generated from the analysis and influenced by the theoretical framework. The study set out to examine or better understand caregiver's perspective on factors affecting medication non-adherence among mental health patients at the Pantang psychiatric hospital. Some findings have been revealed and are discussed in this section.

#### **5.1 Patients-related factors affecting medication non-adherence among mental health patients.**

The findings of the study recorded varied results from the caregivers interviewed at Pantang psychiatric hospital. Among the findings revealed by the respondents interviewed on this question are side effect of medication, harmful effect of the drugs, financial challenges, lack of insight, family influence and religious beliefs, length of time of taking the medication, superstition, hearsay and stigmatization and non-availability of the medication. Thus, the discussion on these research question will be centered on themes that emerged from the data gathered and analyzed above.

##### **5.1.1 Lack of Insight into condition**

When they do not consider their medical plight as a problem it demonstrates how badly insightful they are with conditions they find themselves. Thus, this study revealed that patient sometimes thinks they are well or better still do not believe they are unwell and hence do not need to continue with their medication. This corroborates the study of Staring, van der Gaag, Duivenvoorden, Weiden, & Mulder, (2011) who discovered that a lack of insight, and in particular low recognition of the importance for treatment, was strongly associated with non-adherence within a fraction of patients with schizophrenia. This means patient stand in risk to

his or her own health if such mind set has been formed by him or her. Patients with a lack of insight into their psychiatric disorder have also been found to be at risk of non-adherence (Misdrahi et al., 2012).

### **5.1.2 Financial Challenges**

Furthermore, the findings of the study revealed financial instability as key issues that deter most mental health patient from adhering to medications. This is a common phenomenon in most health care delivery especially where health insurance policy is not effective. Thus, with mental health where medications are so expensive patients may relapse to the former situation if the support is not available augment what they can afford. In support of these findings Adeponle, Baduku, Adelekan, Suleiman, & Adeyemi (2009); Adeponle, Thombs, Adelekan, & Kirmayer (2009) also found that the most common reason for defaulting in mental health reviews was financial instability. It is therefore acknowledged or established in research that financial constraints have been and will always be a challenge.

### **5.1.3 Family Influence**

The findings further revealed that families of these patients are a bad influence when it came to encouragement to adhere to prescribe medication. This shows how the family is such an essential element in the lives of the Africans and for that matter will permeate every facet of their being.

### **5.1.4 Religious Beliefs**

Providing hope based on faith and refuge for patients with mental health appeared to be the very essence of the family and religious influence for non-adherence. In the view of Taylor et al (2004) providing refuge from oppression as well as providing for both the social and economic welfare of the African American individual (Taylor et al, 2004). The findings showed that religions were a big deal in medication non-adhering of patients at the pantang

mental hospital. A recent research examining the relationship between religious involvement and help-seeking behaviors found that even highly religiously involved participants do not seek help from clergy members (Ayalon & Young, 2005). A recent examination of the relationship between religious coping and mental health utilization found that African American college students who more frequently utilized religious coping methods were less likely to utilize mental health services when experiencing subclinical levels of depressive symptoms, however, when experiencing clinically significant levels of depressive symptoms, religious coping was no longer a significant predictor of mental health utilization (Haynes, Kohn-Wood, Hammond-Powell, 2010) indicating that the relationship between religious coping and usage is more complex than previously hypothesized. Despite indications from previous literature (Barksdale and Molock, 2009) and qualitative results that mental health service attitudes mediated the relationship between religious indices and intent to utilize, the quantitative results do not support this hypothesis. Thus, this suggest that it is very difficult to pin down the argument for religion as a basis for non-adherence in spite of the evidence provided by the nurses and the doctors in this study. Thus, findings of this issues were only the views of the prescribers and the nurse. None of the relatives admitted to the fact that they seek religious help on mental health issues.

### **5.1.5 Superstition**

Closely related to the above is the issue of superstition, hearsay and stigmatization. The study revealed that patient have been told a lot of scary incidences or better still been given scary information based on experiences of other patients with respect to the effect of the drugs and therefore have refused to take their medications. Besides, families of these patients also serve as a hindrance to taking of medications. Stigma also influences the interface between mental illness and public identification as “mentally ill” can yield significant harm (Corrigan, 2004)

Research has suggested that people with concealable stigmas (with mental illness) decide to avoid this harm by hiding their stigma and staying in the closet (Corrigan & Matthews, 2003). It is therefore imperative that the public be given some form of education on mental health patient to end stigmatization of mental health patients in our communities and families.

#### **5.1.6 stigmatization**

Stigma has also been associated with non-adherence in schizophrenia (Hudson, et al., 2004). Although progress has been made in altering perceptions about this illness, the public at large remains poorly informed and stigma remains a major problem. This finding was similar to that of this research in that this study found that patients stigmatizing has affected the administration of mental health drugs

#### **5.1.7 Length of Time of Taking the Medication**

Also, closely related to the above the findings showed that most families are the ones who tend to be very concerned and on the bases of that stop their wards from continuing with the medication.

#### **5.1.8 Non-Availability of The Medication**

Another issue revealed by the study is that medication becomes scares or non-available and this affects non-adherence. This create intermittent use of the prescribed drugs and coming back to use it again when it is available becomes a problem for the patients. This implies a poor health system practice at Pantang mental hospital.

### **5.2 Institutional factors affect medication non-adherence in mental health patients**

#### **5.2.1 Cost of medication and admission**

The findings revealed that the price of medication and care is also escalating which is throwing mental health patient back onto the street and their home untreated. The evidence

provided for this revelation was the fact that about one thousand beds at the Pantang hospital is now being occupied by only 150 mental health patients at the hospital currently. This implies the patient is at risk since their mental illness may relapse because they are unable to afford the cost of the medication and admission.

### **5.2.2 Attitude of Health Workers, Ineffective Communication**

Also, on attitude of Health Workers, Ineffective Communication the findings showed that there are pick and choose attitude among the patients in that they have their favorite health worker they prefer to be attended to. This suggest that these mental health patients may not be happy with how some of the health workers handle them or communicate with them

### **5.2.3 Forgetfulness**

The findings showed unless prompted by relatives' patients normally forget to take their medication. This findings support a study conducted by Tesfay, Girma, Negash, Tesfaye, & Dehning, (2013) in which they found that 78.2% attributed their non-adherence of their medication to forgetfulness. When one deviate from the usual way of things it is obvious that he or she may find himself in the realm of forgetfulness.

## **5.3 Community factors that affect medication non-adherence among mental health patients.**

The findings on community factor was that of stigmatization and this stigma is as a result of the open side effect which distort the movement or walking of mental health patients thereby creating or attracting the attention of the community. Thus, members of the community turn to raise question as they find the answers they then resort to gossip and stigmatization. In fact, upon observation of certain unusual changes in their being instigate interest and when members of the community find out then the stigma starts.

The repercussion of this stigma is the fear of being seen taking medication from a psychiatric hospital by other people in the community because of the fear of being tag wrongly

#### **5.4 Pharmacological factors**

Among some of the effect they mentioned are restless, tardive dyskinesia, Parkinsonism and these has really affected non-adherence of medication. This implies that the side effect of the mental health medication is inevitable with most mental health patients. In fact, similar findings were made in a study by(Li & Arthur, 2005) in which they found that majority of clients on typical antipsychotics were found to experience drug side effects such as tremors, muscle rigidity, slurred speech, restlessness, painful muscle spasms and impotence which contributed much to their poor adherence. Thus, is it not strange for the study to note that the side effect will definitely lead to non-adherence of medication. (Janssen et al., 2006) found in their study that a significant association between lower medication adherence and substance abuse, involuntary admissions, history of aggressive behavior and no high school graduation. In other words, higher medication adherence will be realized if the medication could guarantee little or no side effect. Medication effectiveness is one of the most critical issues when prescribing any medication. Thomas (2007) looked at antipsychotic medication effectiveness and adherence. Thomas (2007) discovered that long-term symptom control, tolerability and hence adherence to treatment can all be improved using atypical or second-generation antipsychotic agents compared with typical antipsychotic drugs.

Again, the findings showed that patients sometimes express apprehension on the side effect of the drugs which will not only cause drowsiness, difficulty controlling the tongues, skin rashes, drooling of saliva, twisted neck and weakness but rather the medication will harm them as well. A study by Mensah and Yeboah (2003) using 1,290 Ghanaian psychiatric patients reported that over 80% stopped or interrupted psychotropic medication due to

reasons such as side effects (fatigue and drowsiness), a preference for healing from spiritual churches, and a feeling of recovering.

## CHAPTER SIX

### CONCLUSIONS AND RECOMMENDATIONS

#### 6.0 Introduction

This chapter of the study is composed of the summary of the findings. This is followed by the conclusion and recommendations suggested by the participants to help ensure medication adherence among mental health patients at the Pantang Mental Health Hospital.

#### 6.1 Summary of findings

The major goal of the study was to determine factors affecting medication non-adherence among mental health patients: Care givers perspective. In other words, Doctors (Prescribers), nurses, and relatives of mental health patients at the Pantang Mental Health hospital were interviewed. In all 20 respondents (caregivers) were interviewed and inclusion was that caregivers must be the key caregivers; family caregivers should be more than 18 years and caregivers must have lived with the patient in the same household for more than 6 months. Above all the study adapted the health believe model. The result of the study formed the basis on which the research concluded and adduced some recommendations for the study.

The major findings of the study include the following:

In the study, patients-related, factors affecting medication non-adherence among mental health patients were found to include side effect of medication, harmful effect of the drugs, financial challenges, lack of insight, family influence and religious belief, length of time of taking the medication, superstition, hearsay and stigmatization and non-availability of the medication. Almost all respondents from prescribers, to nurses and relatives affirmed the above findings.

Secondly, on institutional factors that affect medication non-adherence in mental health patients the results revealed that the price of medication and care has escalated and has thrown mental health patient back onto the street and their home untreated. Also, according to the findings patient these days pay their own medication couple with the fact that the medication is expensive also affect adherence to medication.

Furthermore, on community factors affecting medication non-adherence among mental health patients the study found that stigmatization which is a result of the side effect of the medication exposes the mental health patient to the community and hence the stigmatization.

Finally, on pharmacological factors affecting medication non-adherence of mental health patient the study found among others that restlessness, tardive dyskinesia, Parkinsonism and these has really affected non-adherence of medication formed part of pharmacological factors for non-adherence.

## **6.2 Conclusion**

The findings reveal several factors of medication non-adherence from patients-related, factors to institutional factors, community factors and pharmacological factors, thereby providing insight into different non-adherence factors. Clarity is offered by highlighting religious differences and similarities in mental health beliefs and perceptions about the causes of mental health problems. The implications of the studies and recommendations based on current findings are also discussed.

## **6.3 Recommendations**

Based on the results of this study, the following specific recommendations were made and these recommendations are directed to the Pantang Mental Hospital:

- Government, specifically ministry of health must consider allocating enough funds to the Pantang Mental Hospital as well as subsidizing medications to reduce cost of care.
- Ministry of health through mental health authority must develop policy to include mental health services into NHIS which will reduce the burden of cost or care on the patients of Pantang Mental Hospital.
- Decentralization of mental health in Ghana will go a long way to reduce medication non-adherence at the Pantang Mental Hospital as patients may not have to travel long distance to access mental health care, which comes with so much cost as well as strengthening of community psychiatric care to improve home visit, accessibility and reduce the cost associated with facility visits.
- The use of atypical and long acting medications must be promoted by hospital management through Mental health Authority as they have fewer side effects thereby promoting adherence, as side effects of medication is a major factor to non-adherence.
- Pantang Mental Hospital management must ensure constant training and supervision of mental health workers to perform standard psycho-education regularly at the facility.
- Ministry of health, in collaboration with Mental health Authority and the Pantang Mental Hospital must Intensive public health education on mental health as this can go a long way in reducing stigma against mental patients.

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## **APPENDICES**

### **Appendix A: Informed Consent Form**

Project: Title: Caregivers' perspective on factors affecting medication non-adherence among mental health patients at the Pantang Psychiatric hospital.

Please read this consent document carefully before you decide to participate in this study.

#### **Introduction**

I am a student of school of public health University of Ghana Legon pursuing master's in public health. As part of my studies, I intend to do a study titled: Caregivers perspective on factors affecting medication non-adherence among mental health patients.

#### **Purpose of the research study**

The purpose of this study is to determine caregivers' views on patients-related, institutional, community and pharmacological factors affecting medication non- adherence among mental health patients.

#### **Procedure**

The study will involve answering questions from an interview guide about caregivers' perspective on factors affecting medication non-adherence among mental health patients at the Pantang Psychiatric hospital. The information that you are going to give will be recorded with a digital recorder and the researcher will also note down important points. Participation in the study is voluntary and without coercion to obtain responses from participants. Information to be collected includes caregivers' background characteristics such as age, sex, and relationship with patient, and educational status. It will take about 45-60 minutes to complete the interview.

### **Risk and benefits**

There is no potential risk involved in this study. However, few minutes of your time and attention will be required. We do not anticipate that you will benefit directly by participating in this study. However, the study is foreseen to be useful to both the study population and the society at large by helping mental health service providers to identify new interventions for caring for mental health patients and thus reduce relapse rates in patients.

### **Incentive or compensation**

There is no additional credit or other incentive for participating; therefore, you will not be adversely affected in any way if you choose not to participate. However, we will give you snack for your time.

### **Confidentiality**

To ensure privacy, the interview will be conducted in the OPD in-charges office. This will enable participants to remain calm and prevent any form of interruptions. Your identity will be kept confidential. Your information will be assigned a code number. The list connecting your name to this number will be kept in a locked file in the faculty supervisor's office. When the study is over, and the data has been analyzed, the list will be destroyed. Your name will not be used in any report or publication.

### **Voluntary participation:**

Your participation in this study is completely voluntary. Should you opt to discontinue participation; any information already collected will be discarded. You will not be penalized or lose any benefit if you decide not to participate in the study.

**Dissemination of results**

The findings of the study will be disseminated to the management of Pantang Hospital and Mental health Authority. A copy of the study will be kept in the hospital as reference.

**Whom to contact if you have questions about the study:**

Contact Genevieve Awuye –Kpobi (0244136072, arabakpobi@gmail.com). If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you may contact:

Hannah Frimpong (0507041223)

E-mail :( Hannah.Frimpong@ghsmail.org)

GHS-ERC Administrator.

**Agreement:**

If you wish to participate in this study, please sign the form below. A signature will indicate agreement to participate.

Participant’s Name: \_\_\_\_\_

Signature \_\_\_\_\_ (Date) \_\_\_\_\_

**If illiterate**

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness \_\_\_\_\_

Thumb print of participant

Signature of witness \_\_\_\_\_



Date \_\_\_\_\_

## **Appendix B: In-depth interview guide for care-givers**

Care givers who consented to participate in the study will be asked by the researcher to provide their demographic information. This will describe the population and help to build rapport between the participants and the researcher before the in-depth interviews.

### **Demographic data**

ID No.....

Age.....

Sex.....

Level of education.....

Occupation.....

Marital status.....

Relationship with patient.....

### **In-depth interview guide**

#### **Factors to medication non-adherence**

##### **What patients- related factors affect medication non-adherence**

- 1) Probe health beliefs, and religion
- 2) Probe attitudes concerning effectiveness of treatment and lack of motivation
- 3) Probe previous experiences with pharmacological therapies
- 4) Probe low socio-economic status, unemployment and inadequate nutrition
- 5) Probe lack of insight, type of disorder, poor understanding of medication, and lack of involvement in decision making

##### **Health-system factors**

- 1) Probe cost of care (cost of medication, cost of admission)
- 2) Probe attitude of health workers, ineffective communication

**Community factors**

- 1) Probe stigma

**Pharmacological factors**

- 1) Probe type of medication, side effect of medication, frequency of medication, number of medications taken.

What strategies do you use to promote medication adherence?