

UNIVERSITY OF GHANA

COLLEGE OF HUMANITIES

EXPLORING CROSS-PROFESSIONAL COLLABORATIONS AMONG
PROFESSIONAL AND LAY MENTAL HEALTH PRACTITIONERS TOWARDS
SCHIZOPHRENIC CARE IN GHANA

BY

RITA NKRUMAH

(10312400)

THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON
IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MPhil
CLINICAL PSYCHOLOGY DEGREE

JULY, 2017

DECLARATION

I hereby declare that with the exception of the references used which are duly acknowledge, this thesis is my own work submitted for the award of MPhil Clinical Psychology to the Department of Psychology, University of Ghana.

Rita Nkrumah

.....

(Student)

Prof C. Charles Mate Kole

.....

(Principal Supervisor)

Dr Annabella Osei Tutu

.....

(Co-Supervisor)

DEDICATION

I dedicate this master thesis to the Almighty God for His abundant Grace and Wisdom.

ACKNOWLEDGEMENT

Glory be unto the name of God for His grace and favour has been sufficient. The production of this work has received the support from individuals who deserve much acknowledgement and gratitude. I am much grateful to my first supervisor Professor C.C. Mate-Kole whose suggestions, advice and directives guided my thoughts and the writing of this thesis. The reception of your patience, enriching academic knowledge and research training can never be underestimated. To my second supervisor Dr. Annabella Osei-Tutu, I appreciate your corrections and guidance. Special gratitude goes to my Mum, Professor and Mrs Asiamah Yeboah for your prayers and support in all spheres of my life. I say thank you. Lastly, I wish to extend my gratitude to all friends including anonymous reviewers who supported me in one way or the other.

TABLE OF CONTENTS

DECLARATION	i
DEDICATION	ii
ACKNOWLEDGEMENT	iii
TABLE OF CONTENTS.....	iv
LIST OF TABLES.....	vii
LIST OF FIGURES.....	viii
ABSTRACT.....	ix
CHAPTER ONE	1
INTRODUCTION.....	1
1.1 Background of the Study.....	1
1.1.1 Movement for Collaborative Care in Mental Health Delivery in Ghana.....	2
1.1.2 Factors Affecting Collaborative Mental Health Care	3
1.2 Statement of the Problem.....	5
1.3 Aim and Objectives of the Study.....	6
1.4 Research Questions	6
1.5 Operational Definitions of Terms	7
1.6 Relevance of the Study	8
CHAPTER TWO	9
LITERATURE REVIEW	9
2.1 Introduction.....	9
2.2 Theoretical Framework.....	9
2.2.1 Collaborative Care Model	10
2.2.2 Three-System Model of Integrative Mental Healthcare	11
2.2.3 Three-Step Model of Integrative Mental Healthcare (Osafo, 2016).....	13
2.3 Review of Related Studies	15
2.3.1 Areas of consensus among different systems of treatment	16
2.3.2 Internal and Cross-professional Collaborative Challenges.....	17
2.3.3 Integrating the Models	19
2.4 Rationale for the Study.....	20
2.5 Statement of Hypotheses for Quantitative Part.....	22
2.6 Conceptual Model for Quantitative Part of the Study	22
CHAPTER THREE	24
METHODOLOGY	24
3.1 Introduction.....	24

3.2	Research Design	24
3.3	Sample Technique and Sample Size	25
3.4	Study 1: Quantitative study.....	26
3.4.1	Research design for the Quantitative study.....	26
3.4.2	Study setting.....	26
3.4.3	Population for the quantitative Study	27
3.4.4	Quantitative Sample.....	27
3.4.5	Measures and Instruments	29
3.4.6	Quantitative Measures.....	29
3.4.7	Procedures for Data Collection	31
3.4.8	Piloting the quantitative instruments	31
3.4.9	The Main Study	32
3.4.10	Ethical Consideration	32
3.4.11	Quantitative Data Analyses.....	32
3.5	Study 2: Qualitative study.....	33
3.5.1	Research design for qualitative study.....	33
3.5.2	Qualitative Sample	34
3.5.3:	Measures and Instruments for qualitative study.....	36
3.7.1	The Pilot Study for qualitative study.....	38
3.7.2	The Main Study for qualitative.....	38
3.7.3	Qualitative Data Analyses	38
CHAPTER FOUR	41
RESULTS	41
4.1	Introduction	41
4.2	Study 1: Quantitative Results.....	42
4.2.1	Preliminary Data Analysis.....	42
4.2.3	Test of Hypotheses.....	44
4.2.4	Group Differences in Attitude towards Collaborative Care	44
4.2.6	Group Differences in Attitudes towards Patients with Schizophrenia	47
4.2.7	Exploratory Factor Analysis for the Construct Validity of Scales	49
4.2.8	Exploratory Factor Analysis of Attitude towards Patients with Schizophrenia Scale	49
4.2.9	Exploratory Factor Analysis of Stigma towards Practitioners Who Treat Schizophrenia Scale	52
4.2.10	Exploratory Factor Analysis of Attitude towards Collaboration Instrument	56
4.2.11	Summary of Findings from Study 1	59

4.2.12 Observed Model for Study 1	59
Figure 2: Observed Model for Factors Associated with Schizophrenic Care	60
4.2.13 Brief Interpretations of Study 1	60
4.3 Study 2: Qualitative Findings.....	61
4.3.1 Representations of Schizophrenia among Non-professional Mental Health Practitioners.....	62
4.3.2 Willingness of Professional Mental Health Practitioners to Collaborate.....	75
4.3.3 Brief Interpretations of Qualitative Findings.....	85
CHAPTER FIVE	87
DISCUSSION.....	87
5.1 Introduction.....	87
5.2 Discussion of Quantitative Findings	89
5.2.1 Attitudes towards Collaborative Schizophrenic Care.....	89
5.2.2 Stigma Associated with Schizophrenic Care.....	90
5.2.3 Attitudes towards Patients with Schizophrenia.....	91
5.3 Discussion of Qualitative Findings.....	92
5.3.1 Representations of Schizophrenia among Non-Professional Mental Health Practitioners in Ghana.....	93
5.3.2 Perspectives on Collaborative Care.....	97
5.4 Limitations of the Study.....	100
5.5 Recommendations Based on the Study.....	101
5.5.1 Practical Recommendations.....	101
5.5.2 Recommendations for Future Research	102
5.6 Conclusion	103
REFERENCES.....	106
APPENDICES	112
APPENDIX A.....	112
APPENDIX B.....	116
APPENDIX C.....	117
APPENDIX D.....	118

LIST OF TABLES

Table 3.1: Demographic Characteristics of Survey Participants (N =110).....	28
Table 3.2: Demographic Characteristics of Interview Participants (N = 30).....	35
Table 3.3: Sample Questions in the Interview Guide.....	37
Table 4.1: Summary of Means, SD, Reliability, Skewness and Kurtosis of Variables.....	44
Table 4.2: Summary of MANOVA results for Attitude towards Collaborative Care.....	45
Table 4.3: Summary of MANOVA results for Stigma Associated with Schizophrenic Care.....	46
Table 4.4: Summary of MANOVA results for Attitudes towards Patients with Schizophrenia.....	48
Table 4.5 (Factor 1): Stigmatizing Attitude sub-scale.....	50
Table 4.6 (Factor 2): Supportive Attitude sub-scale.....	51
Table 4.7 (Factor 3): Discriminating Attitude sub-scale.....	52
Table 4.8 (Factor 1): Discrimination Sub-scale.....	53
Table 4.9 (Factor 2): Positive Aspect Sub-scale.....	55
Table 4.10 (Factor 3): Disclosure Sub-scale.....	55
Table 4.11 (Factor 1): Competence Recognition Sub-scale.....	57
Table 4.12 (Factor 2): Open Communication Sub-scale.....	58
Table 4.13: Summary of key qualitative findings (N=30).....	84

LIST OF FIGURES

Figure 1: Hypothesized Model for Factors Associated with Schizophrenic Care.....	23
Figure 2: Observed Model for Factors Associated with Schizophrenic Care.....	60

ABSTRACT

Ghana is grappling with inadequate professional mental health practitioners for the treatment of schizophrenia. Since many patients partly access the services of non-professional mental health practitioners, implementation of collaborative framework will potentially ensure effective and quality delivery of schizophrenic care. This study examined opinions about the different collaborative frameworks between professional and non-professional mental health practitioners for the delivery of schizophrenic care. Field research data was collected from three regions in Ghana using mixed research design. The survey involved 110 practitioners and the interviews involved 30 practitioners. The quantitative data was analysed using multivariate analysis of variance. The second study which is the qualitative part was analysed using thematic analysis. The findings showed that professional mental health practitioners show significantly more positive attitudes towards collaborative schizophrenic care than the non-professional mental health practitioners. Professional mental health practitioners experienced higher levels of stigma associated with schizophrenic care than non-professional mental health practitioners. Pastors had more positive or supportive attitudes towards patients with schizophrenia, compared to other non-professional mental health practitioners. The qualitative findings revealed that lay practitioners understanding of schizophrenia is marked by mainly the pattern of their symptoms. It was also observed that categorization of schizophrenia is still strongly held among the lay practitioners. The findings are discussed in relation to enhancing schizophrenic care and mental health in Ghana.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Ghana, like many other sub-Saharan African countries is faced with high mental health challenges (Ofori-Atta, Read, & Lund, 2010). This manifests in the form of inadequately trained mental health personnels who will provide mental health services to the people (Ofori-Atta et al., 2010). There are few trained psychologists, psychiatrists and psychiatric nurses and they are mostly based in the urban centres. This has created a situation where majority of the population do not have access to trained mental health practitioners (Ae-Ngibise et al., 2010).

In response to this increasing gap, there has been a movement away from institutional care towards community care (de-Graft Aikins, 2002). The movement towards a community-based care in low and middle income countries has also coincided with the call for collaborations between different systems of health practitioners (de-Graft Aikins, 2002). With the call for collaborative care increasing, there is the need for empirical research that examines the various dynamics involved in the readiness for collaboration among different professionals and non-professionals in the field of mental health delivery in Ghana.

The significance for understanding collaborative care requires research examining perspectives of mental health practitioners on the factors underpinning collaboration. This will be a wake-up call to bringing different practitioners with different ethos for diagnosing and treating mental disorders. The current study contributes empirical evidence to the dialogue by using

schizophrenic care as a case study to examine the dynamics of cross-professional collaboration in mental health delivery in Ghana.

The current study is done from social constructivist paradigm, within critical clinical psychology perspective that places emphasis on how socio-cultural context shape science and therapy in mental health delivery (Rhodes & Conti, 2016). The need for examining this issue from a critical psychology perspective is imperative because, as some scholars (e.g. Coles & Mannion, 2017) within the field of clinical psychology argue, the pursuit of professional interest has the potential for undermining the delivery of contextually-relevant mental health care.

1.1.1 Movement for Collaborative Care in Mental Health Delivery in Ghana

In sub-Saharan African context, traditional healers and faith-based healers are held in high esteem with great respect for their practice among the general population (de-Graft Aikins, 2005). Patients seeking mental health care in general and schizophrenic care in particular go round ‘shopping for healers’ for their health problems from all these treatment sources (de-Graft Aikins, 2005). There are ample evidence to show that for most families seeking schizophrenic care in particular for their relatives, traditional and faith-based healers are their first point of call (Asamoah, Osafo, & Agyapong, 2014; Barimah & Akotia, 2015; J Osafo, Agyapong, & Asamoah, 2015). Ghana therefore serves as a good context for researching collaborative care in mental health delivery.

According to Warner (2009), Collaborative Care is defined as a system of health delivery approach where different healthcare professionals are brought together to provide holistic care and monitor patients’ progress (Warner, 2009). Within the context of Ghana, collaborative care is conceptualized in the current thesis as a team-driven mental health delivery where

professional or medical mental health practitioners and non-professional practitioners are brought together to provide holistic schizophrenic care.

The Health system in Ghana and mental health system in Ghana is considered to be very pluralistic (de-Graft Aikins, 2005). Mental health delivery in Ghana for instance is in the hands of trained biomedical practitioners (psychiatrists, psychologists and psychiatric nurses), traditional healers (herbalists) and faith-based healers (traditional priests, neo-prophetic ministers, Pentecostal clergy, Imams) (Barimah & Akotia, 2015; J Osafo et al., 2015).

Comparatively, the services of traditional and faith-based healers are easily accessible to patients relative to trained mental health professionals (Ae-Ngibise et al., 2010). This easily accessibility places the traditional and faith-based healers in direct contact with majority of the people than the trained mental health practitioners. These non-professional mental health practitioners are actively engaged in the delivery of mental health services to majority of people. There have been many concerns raised with regards to their practices such as the allegations of human right abuses of mental health patients (de-Graft Aikins, 2015).

The argument therefore is that, indisputably, people with mental health problems seek help from these lay mental health practitioners (Ae-Ngibise et al., 2010). In this regard, establishing collaborative framework to recognise and include them in mainstream health delivery will serve to augment the mental health personnels in Ghana and also stop the abuses through training (Ae-Ngibise et al., 2010).

1.1.2 Factors Affecting Collaborative Mental Health Care

Several different factors have been argued to affect the readiness of different practitioners to collaborate in delivering care. In the context of mental health care in sub-Saharan Africa,

stigma is a serious problem that shape how people experience giving and receiving mental health treatment (de-Graft Aikins & Koram, 2017; Jacob, 2017).

This is especially so for schizophrenic care. In Ghana, patients with schizophrenia are stigmatized and discriminated against. The stigma appears to affect both patients and mental health practitioners. The mental health practitioners experience this stigma in the form of courtesy stigma; which is stigma experienced as a result of associating or being involved with a stigmatized person or group (de-Graft Aikins, 2015). Apart from the stigma held by the general population, the practitioners involved in delivering schizophrenic care also hold some level of stigma towards schizophrenia and schizophrenic patients (González-Torres, Oraa, Arístegui, Fernández-Rivas, & Guimon, 2007; Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013).

The attitudes that practitioners hold about mental health condition affect their diagnosis and treatment practices (Magliano et al., 2016). The stigmatizing attitudes practitioners have about schizophrenia do not only affect how they treat patients with schizophrenia but also affect their attitudes and readiness to collaborate with other practitioners for delivery treatment to patients with schizophrenia (Komiti, Judd, & Jackson, 2006).

As part of the objectives of the current study, stigma experienced by the different forms of practitioners providing schizophrenic care and their attitudes towards collaborative care are also examined. Understanding the stigma they experience and the attitudes they hold about collaborative schizophrenic care would provide deeper understanding into some of the factors that underpin collaborative mental health care delivery in resource-poor contexts such as Ghana.

1.2 Statement of the Problem

In Ghana, there are more people accessing mental health services from non-professional mental health practitioners compared to trained mental health professionals for various reasons including affordability and availability (Barimah & Akotia, 2015). Majority of the people also tend to retain confidence in faith-based healers for alleviation of mental health problems (Ae-Ngibise et al., 2010).

These systems have different explanatory models of mental illness which always create tension between the practitioners. The differences in their explanatory models of mental illness influence different systems of treatment for same mental disorders (Magliano et al., 2016).

As people are actively engaging the services of both professional and non-professional mental health practitioners, they are at risk of combining different treatments which may worsen their condition. Thus the attempt to establish collaboration is in the right direction to streamline and regularise the activities of the different systems of health (Barimah & Akotia, 2015).

Different systems of establishing collaboration have been established however, to our knowledge there has not been much empirical studies that examined the views of professional and non-professional mental health practitioners concerning the type of collaborative systems they will be ready to work with. However, it requires an effectively planned approach to developing a collaborative framework that will be accepted by all stakeholders in mental health delivery in Ghana. It is important to examine all possible factors that can influence collaboration between the practitioners. Using schizophrenic care and treatment in Ghana as a case study, this study sought to examine practitioners' views on the different systems of collaborations and also examine the dynamics of cross-referral, which is an important characteristic of collaboration.

1.3 Aim and Objectives of the Study

The main aim of the study is to examine opinions about the different collaborative frameworks between professional and non-professional mental health practitioners using schizophrenic care in Ghana as a case study. Specifically, the study seeks to:

- i. Examine what attitudes towards collaborative schizophrenic care held by professional and non-professional mental health practitioners
- ii. Assess levels of stigma experienced by professional and non-professional mental health practitioners
- iii. Explore the understandings of schizophrenia among non-professional mental health practitioners and how their understanding shape treatment practices
- iv. Explore the views, opinions and preferences of the different collaborative systems (cooperation, incorporation and total integration) between professional and non-professional mental health practitioners with regards to schizophrenia care
- v. Explore the dynamics of cross-referrals of schizophrenic cases among professional and non-professional mental health practitioners

1.4 Research Questions

Based on the specific objectives of the study, the current thesis seeks to answer the following research questions.

1. What attitudes do professional and non-professional mental health practitioners hold in Ghana hold toward collaborative schizophrenic care?
2. What are the levels of stigma experienced by professional and non-professional mental health practitioners?

3. What are the understandings of schizophrenia among non-professional mental health practitioners and how their understandings shape their treatment practices?
4. What collaborative models (cooperation, incorporation and total integration) do professional and non-professional mental health practitioners prefer?
5. Which of the dynamics of cross-referrals of schizophrenic cases do professional and mental health practitioners prefer?

1.5 Operational Definition of Terms

Terms used in the study are defined as follows:

1. Allopathic practitioners/orthodox practitioners: these refer to professional mental health practitioners (psychiatrists, psychiatric nurses, clinical psychologists etc.) in my study.
2. Lay mental health practitioners: these refer to non-professional mental health practitioners (Neo-prophets/pastors, traditional priests, herbalists and “mallams”) in my study.
3. Representations of schizophrenia: understanding of schizophrenia among lay mental health practitioners.
4. Attitudes towards collaborative care: this is defined by scores on Attitudes towards Collaboration instrument.
5. Attitudes towards schizophrenia: this is defined by scores on Attitudes towards patients with schizophrenia scale.
6. Stigma towards practitioners who treat schizophrenia: this is defined by scores on Stigma towards practitioners who treat schizophrenia scale.

1.6 Relevance of the Study

The study is relevant because the need for collaborative care is not just one of the options of delivering mental health care, but in Ghana, it is the only option. The debate has therefore moved from whether or not there is a need for collaborative care to discussions of the best way to ensure efficient collaborative care. This part of the debate requires empirical evidence from the perspective of different stakeholders involved in mental health delivery in Ghana.

Findings from the current study provide in-depth understanding of the dynamics and the nuances that participants perceive collaborative care and how those shape their preferences for the different systems of collaborative care. These findings provide empirical evidence that shape policy interventions aimed at building vibrant and efficient collaborative mental health care in Ghana in particular and in sub-Saharan Africa in general.

The study provides additional knowledge and ensures theoretical development. The new findings and the integrated model derived from the literature to guide the research process could help future research designs and processes.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter situates the current study within relevant literature concerning attempts at integrating various systems of health provisions. The two models that will serve as the framework for the current study are first considered. The chapter is then proceeded with a review of related studies. It takes a critical look at the relevant studies in the light of the study objectives. A rationale that seeks to justify the current study is discussed and then key variables of the study are highlighted. A new model is afterwards derived from the two models and the literature reviewed. A rationale that seeks to justify the current study is discussed and then key variables of the study are highlighted.

2.2 Theoretical Framework

More recently, debate in the area of collaborative care has shifted from the type of interaction between systems to how the allopathic mental health practitioners and faith-based sectors can collaborate to bridge the gap in care and treatment, recognizing that these two systems often work in parallel (Hansdak & Paulraj, 2013). Research on collaborative mental health care has provided different models for integrating multiple healing systems together in a way that they can work hand-in-hand in delivering holistic care to mental health patients.

For the purposes of the present study, two models were used as a framework to empirically examine the dynamics of bringing together different systems of mental health delivery in Ghana. They are the three-system model of integrative mental health care and the collaborative

care model. A further three-step model to integrative mental health care is used to support the framework.

2.2.1 Collaborative Care Model

According to the Canadian Psychiatric Association and the College of Family Physicians of Canada, collaborative mental healthcare is defined as care that is delivered by providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support (Kates et al., 2011). Inter-professional collaboration (IPC) is mostly regarded as principal element underpinning Collaborative Care Model. However, a key component of collaborative care that must not be overlooked is the involvement of patients and families in treatment choices and execution (Jeffries, Slaunwhite, & Wallace, 2000). This makes collaborative health care to be seen as patient-oriented care where the patient's goals and behavioural orientations are given the highest priority (Sidani & Fox, 2014). In this case, the collaborative health professionals integrate patient perspective in the treatment decision-making process (van Dongen et al., 2016).

However, the approach to collaborative care is not limited to the patients' involvement only. The World Health Organization outlines that the collaborative health professionals should rather work together with both the patients, families, caregivers, and communities for the delivery of the highest quality of care (Gilbert, Yan, & Hoffman, 2010). Thus Collaborative Care Model provides a framework for simultaneous interactions involving the patient, professionals (generalists and specialists) and different agencies, including those in primary, secondary, and tertiary health settings, as well as in social care settings (McKinlay, Morgan, Gray, Macdonald, & Pullon, 2017).

Collaborative care more broadly encompasses a number of primary health care interventions that are fundamentally patient-centred to increase access and availability to appropriate care. Among some interventions for collaborative care include coordination, co-location and integration. Other interventions may include inter-organizational collaboration, self management support, psycho-education for patient and families, enhanced referral system etc. (Jeffries et al., 2000).

The collaborative care model has also been used to guide the collaboration between professional health and non-professional health practitioners. In the context of schizophrenic care, this study assumes that holistic assessment and treatment of schizophrenia requires that professional mental health practitioners such as clinical psychologists operating in the allopathic health system and non-professional practitioners such as traditional priests of the faith-based health system come together to develop collaborative treatment.

2.2.2 Three-System Model of Integrative Mental Healthcare

Although various studies have shown that collaboration between allopathic (i.e. psychiatrists, clinical psychologists, psychiatric nurses and community mental health officers) and faith based systems could contribute to reducing the fragmentation arising from parallel but disconnected systems, the attempt has been met with scepticism regarding the value of faith-based systems (Shields et al., 2016). This has shifted focus to the various means of by-passing these challenges to ensure the different systems work together.

Freeman and Motsei (1992) in their assessment of the role of traditional healers in health care in South Africa proposed a three-system model to configure collaboration between faith-based and allopathic systems of health care. The model identified three different systems of

configuring how the different system of health delivery can work together; *incorporation*, *collaboration/cooperation* and *total integration*.

The incorporation system involves faith-based and traditional healers incorporated into the mainstream health care system within a primary care approach as first-line health practitioners (Freeman & Motsei, 1992). With this system, all the three systems of health care delivery will be under the control of centralised state agency like the Ghana Health Service under the Ministry of Health in Ghana. This means that structural policies concerning public health will be binding not only on allopathic system but also faith-based and traditional healer. Thus, some proportion of the high level of autonomy which faith-based and traditional healers enjoy would be curtailed and their activities regulated.

In the cooperation/collaboration system, faith-based, traditional and allopathic health systems remain autonomous and retain their own practices and methodologies, while practitioners from the three systems co-operate through recognition of the importance and value of all three systems and mutual referral of patients (Shields et al., 2016). With this system, faith-based and traditional healers will not be under the full control of the Ghana Health Service as in the case of incorporation. They would still retain their autonomy in terms of their diagnoses process and treatment practices and procedures. The cooperation would work on the account of respect and recognition of all three systems of healthcare to facilitate cross-referrals.

The total integration constitutes an evolution of a new and blended system, in which both systems provide one packaged treatment (Shields et al., 2016). With this system, diagnoses and treatment regimen will not be complete until probably two or more of the systems are brought

on board. Thus, all the different systems of health delivery (allopathic, faith-based and traditional healing) are probably housed in one health centre to ensure the kind of blend or one packaged treatment that may be required under the total integration system. This system would call for a total control over faith-based and traditional healing practices by the Ghana Health Services which would erode any form of autonomy they enjoy.

2.2.3 Three-Step Model of Integrative Mental Healthcare (Osafo, 2016)

Joseph Osafo (2016) in a review of challenges of collaboration between faith-based healers and professional mental health workers within Ghana's mental health landscape provided an idea within which collaborative linkages between religious leaders (e.g., the clergy, traditional healers) and professional mental health workers can be established and maintained. Osafo (2016), proposed a three-step model that can foster a collaborative framework between non-professional mental health workers (such traditional or faith-based healers) and professional mental health workers. The three steps in the model are understanding, task shifting and broadened curricula.

In the Osafo's (2016) model, the first step requires an understanding (and appreciation) of the explanatory models of mental illness between both professional and non-professional mental health workers. The model conceptualises the first step (understanding) as critically dealing with the tradition of tension that has characterised the discourse on collaboration between professional and non-professional mental health workers. The tension between these two systems of mental health delivery is itself a product of the long-held tradition of tension between science and religion (Osafo, 2016). This tension is seen as two diametrically opposite systems of knowledge in explaining experiences including diseases in general (Osafo, 2016).

The focus in this research is to understand this tension with regards to mental health disorders in Ghana.

The tension is sustained in mental health delivery because of the different explanatory models of the aetiology of mental illness between non-professional and professional mental health workers. This creates a situation where there is lack of space within allopathic health system for spiritual attribution for mental illness and a lack of space in faith-based healing for bio-psychosocial attributions of the aetiology of mental illness.

The second stage of the three-step model is the idea of task shifting. This second step in Osafo's (2016) model borrows from WHO's innovation of moving specific tasks (where appropriate) to health workers with shorter and fewer qualifications to practice, as a mitigating factor of dealing with the huge treatment gap in developing countries as a result of inadequate health personnel (WHO, 2007).

The second step of the model is built on three realities of non-professional mental health workers in Ghana; (1) faith-based healers are widely distributed in Ghana and are found in all corners in Ghana which makes them have direct contact with communities; (2) they are already (officially or unofficially) engaged in mental health delivery for centuries and (3) their patronage has always been increasing (Asamoah et al., 2014). In view of these, shifting some mental health tasks to these non-professional mental health workers through training can go a long way to close the wide treatment gap in mental health care in Ghana.

The third stage of the model is the concept of a broadened curricular. Osafo (2016) argued that, “in the face of this apparent lack of training in spirituality in health care, the need to consider expanding the curricula of health workers in training (e.g., medical practitioners, nurses, social workers, clinical psychologists, and psychiatrists) cannot be overemphasized” (p. 503).

However, the argument seems to be one sided at this stage which is broadening the curricular of professional mental health workers to embrace spiritual explanatory models of mental illness. Drawing on his research experience, he contrary observed that the clergy are enthusiastic about attending training workshops on suicide and suicide prevention which led him to conclude that the religious leaders (clergy) might be ready to embrace training in mental health issues. By this, it can be indirectly deduced that non-professional mental health workers might be ready to learn and incorporate bio-psychosocial models in their attribution of the aetiology of mental illness. However, this requires further empirical investigations and also including leaders from other religions who also form part of the non-professional mental health workers.

2.3 Review of Related Studies

Research studies that have explored potential collaborations between different systems of treatment have come from mainly qualitative methodology (Campbell-Hall et al., 2010). The collaborative framework has been explored across different conditions including the treatment of HIV/AIDS, diabetes and mental illness in general (Cheever, Kresina, Cajina, & Lubran, 2011). These studies revealed complex and more nuance findings with regards to the different treatment systems working together.

The literature shows that in some regards, *there are more areas of consensus than conflict* (de Graft Aikins, 2005; Kayombo et al., 2007; Madiba, 2014). On the other hand *collaboration is characterised by both internal and cross-professional challenges* (Ae-Ngibise et al., 2010; Aikins, 2005; Asamoah et al., 2014; Campbell-Hall et al., 2010; Morant, 2006; J Osafo et al., 2015; Shields et al., 2016; Strayer, 2013). These findings will serve as themes to guide the presentations of the review of related studies.

2.3.1 Areas of consensus among different systems of treatment

The relationship between the different systems of health (traditional and allopathic) has always bothered on tension in relations to different ideologies concerning health and illness which happen to cause friction between them (Osafo, 2016). However, some studies have reported that there are more areas of consensus between these different health systems which can enhance cooperation between them in the delivery of healthcare (de-Graft Aikins, 2002).

For instance, in the examination of ethnomedical and biomedical representations of chronic illness in Ghana, de-Graft Aikins (2002) observed that there are many areas of consensus between ethnomedical and biomedical practitioners on the broader themes of health, illness and treatment processes. Using diabetes care in Ghana as a case study, she found among a group of seven (7) biomedical (doctors and nurses) and eight (8) ethnomedical (herbalists and priests) that there is a scope for collaboration because both groups share more consensual ideas about the diverse causes of diabetes which requires different system of treatment at the biological, psychological and the social levels.

Similar findings have been reported between traditional and biomedical healers in the treatment and management of HIV/AIDS in Tanzania. Kayombo et al., (2014) found among a group of traditional healers who (claim) to be involved in the treatment of HIV/AIDS, that they were willing to collaborate and open doors to other practitioners. Madiba, (2014) also reported similar findings in the treatment of HIV/AIDS in Bostwana. In a semi-structured interview with 39 traditional health practitioners, Madiba, (2014) reported that the traditional healers had positive attitude towards biomedical health practitioners and referred to them as colleagues. As such, the traditional practitioners reported of being willing to share knowledge with the biomedical practitioners, refer patients to them, and are eager to learn biomedical skills from them.

2.3.2 Internal and Cross-professional Collaborative Challenges

Despite the seemingly positive reports of possibility of cross-professional collaborations, there are still pressing challenges that fuels tension between biomedical practitioners and ethnomedical practitioners. The tension has mainly been found to be on the ideologies surrounding aetiology of illness. For example, Shields et al., (2016) examined origins, use and outcomes of a collaborative programme between faith-based and allopathic mental health practitioners in India.

Using in-depth individual interviews with 16 faith-based and allopathic practitioners, Shields et al. (2016) observed that collaboration is extremely challenging and will require trust, rapport-building and extensive open dialogue. The faith-based practitioners were reported to perceive allopathic mental health practitioners of intrusion into their territory which they thought as posing a threat to their livelihood.

Similar findings have been reported in Ghana concerning the tension between traditional healers and biomedical practitioners. Aye-Engibise et al., (2010) has also reported in Ghana that the relationship between the two systems of mental health delivery is characterised by lack of mutual respect, suspicion of traditional healers by biomedical practitioners and as such least likely to collaborate with each other.

Campbell-Hall et al. (2010) have also reported among traditional healers in mental health delivery that even though they are open to training in biomedical approaches to mental health treatment, Western biomedical mental health practitioners are less interested in any collaborative arrangements. This has also been recorded in Ghana among biomedical and ethnomedical practitioners in the treatment of diabetes (de-Graft Aikins, 2005).

In Ghana, research on faith-based approach to the treatment of health problems has expanded to include a new brand of prophetic Christian ministers who are also engaged in health service delivery. Osafo et al. (2015) conducted in-depth interviews with 12 neo-prophetic ministers in Ghana on mental health delivery and reported that these neo-prophetic ministers viewed mental illness as a spiritual problem rather than a biomedical one. They therefore use two main approaches in their treatment of mental illness; hope induction approach and prophetic deliverance approach to treat psychopathologies (Osafo, 2015). Similar findings have also been observed among Pentecostal clergy in Ghana concerning mental illness. Asamoah et al. (2014) reported among 20 male Pentecostal clergy that they lean more towards a diabolical explanatory model of mental health than a biomedical model.

Thus, in Ghana, both neo-prophetic ministers and Pentecostal clergy subscribe to spiritual (which is always diabolical) explanatory of mental illness. This explanatory model coincides with those of other faith-based healers such as traditional priests, Imams and herbalists. But as to whether the similarities between their explanatory models of mental illness will encourage collaboration between them needs further empirical investigation, especially taking into consideration the fact that they belong to different religions within which their actions and practices are deeply rooted.

2.3.3 Integrating the Models

Based on the models and the related literature outlined above, the study derives a new model to guide the research process. The study conceptualises collaborative schizophrenic care as a system of care where mental health professionals and non-professionals adopt collaborative mechanisms to provide holistic care to patients with schizophrenia. In other words, it is a mental health practice where ideas, opinions, knowledge and techniques are holistically harnessed from both allopathic and faith-based health systems for the delivery of schizophrenic care. The new model posits that incorporation, cooperation and total integration (Freeman & Motsei, 1992) are useful collaborative mechanisms for schizophrenic care where interventions such as cross-referral, task-shifting and broadened curricula (Osafo, 2016) are executed. Success of these processes and interventions occurs where recognition, trust and mutual respect are observed.

The integrated model seeks to underscore the need for collaboration between professionals and non-professionals in the treatment of schizophrenic care. They include understanding of schizophrenia, the nature of collaborative models or intervention, the attitude towards

schizophrenic care and stigmatisation between professionals and non-professionals. Thus these variables affect the willingness or readiness of these diverse practitioners to collaborate or not. The understanding of schizophrenia is dependent on how the practitioner is oriented in a particular system whether allopathic or faith-based health system. This informs the practitioner's diagnostic processes and treatment practices. The preference for a particular collaborative model or intervention, the attitude towards schizophrenic care and stigmatisation between professionals and non-professionals are also influenced by the perception and knowledge of particular mental health system (allopathic or faith-based health system). In view of this, there is potential consensus and conflict/disagreement that could emerged in implementation of collaborative mental health care system. The integrated model provides a framework for assessing not only the cross-collaborations between practitioners in the delivery of schizophrenic care but also the sources and impacts of the conflicts and how the consensus could be sustained.

2.4 Rationale for the Study

The literature shows that considerable attention has been paid to exploring the possibility of collaborative relationship among the various systems of treatment. However, there are still some gaps that still need further empirical examination. For instance, most studies have looked at the possibility of collaboration between biomedical and traditional healers in the treatment of chronic conditions diabetes, HIV/AIDS and mental illness. Based on the framework above, there are different forms of that this collaborative work can take; cooperation, incorporation and total integration. However, none of the studies have taken a critical look at which of the systems of collaborations that the practitioners will actually endorse in practice.

Again, the issue of cross-referrals features strongly in the dialogue on collaborations between the practitioners. Ghana's health system is found to be highly pluralistic (de-Graft Aikins, 2005) with different practitioners in the in the delivery of mental health including biomedical practitioners, herbalists and faith-based practitioners (traditional priests, neo-prophetic ministers and Pentecostal clergy) (Barimah & Akotia, 2010; Osafo et al., 2015). However, no empirical study till now has examined the dynamics of the cross-referral system among the practitioners. For instance, which practitioners will a traditional priest refer a patient to and why is still not clear from the literature.

The third issue is the fact that when it comes to collaborative treatment of chronic illnesses, different conditions are examined for their peculiarities. Conditions that have received much attention so far have been diabetes and HIV/AIDS. But when it comes to collaborative works on treatment of psychopathologies, all of them are put together. There has not been any empirical study by far, that have examined the dynamics of collaboration with regards to the treatment of a particular mental disorder.

This study fills the gaps in three main ways. First, this study uses the treatment and management of schizophrenia in Ghana as a case study to examine the dynamics of collaboration among the practitioners. By so doing, this study provides valuable insights into how different condition may influence collaboration among the practitioners. Also, the study will examine the views and preferences on the different forms of collaborations and whether practitioners are open to learning explanatory models of schizophrenia from other practitioners. Finally, the study will explore the dynamics of cross-referrals with regards to treatment and management of schizophrenia.

2.5 Statement of Hypotheses for Quantitative Part

The following hypotheses are formulated for study 1:

H1: Professional mental health practitioners will report more positive attitudes towards collaborative schizophrenic care than the non-professional practitioners.

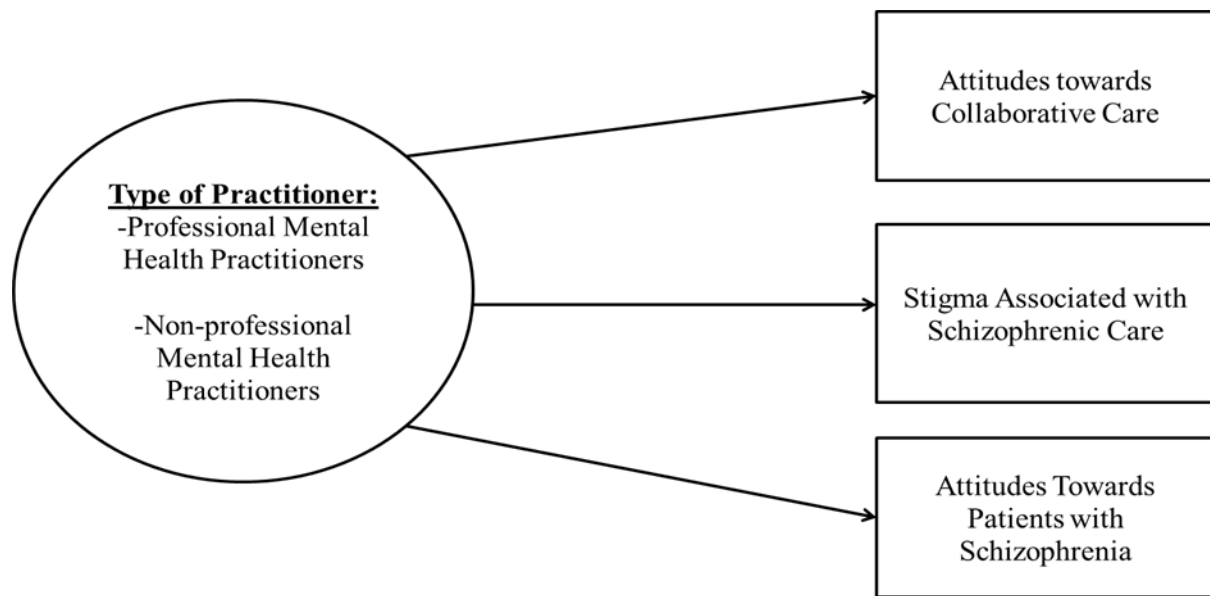
H2: Professional practitioners will experience higher stigma associated with schizophrenic care than the non-professionals.

H3: There will be significant differences in attitudes towards patients with schizophrenia among the practitioners.

2.6 Conceptual Model for Quantitative Part of the Study

Study 1 (the quantitative component) examined differences factors associated with schizophrenic care in Ghana. It is hypothesized that professional and non-professional mental health practitioners would differ in terms of their attitudes towards collaborative care, stigma associated with schizophrenic care and attitudes towards patients with schizophrenia.

Figure 1: Hypothesized Model for Factors Associated with Schizophrenic Care



CHAPTER THREE

METHODOLOGY

3.1 Introduction

In this methodology chapter, the processes that were followed in gathering data to answer the research questions are presented. The chapter contains a detailed description of the design of the study, study setting, population studied, sampling technique and sample size, data collection procedures, data analyses and ethical consideration.

3.2 Research Design

The study used a mixed-method approach to gather both quantitative and qualitative data to answer the research questions. Mixed-method approach was used because of its utility of addressing potentially complex psychological issues in diverse socio-cultural contexts (Braun & Clarke, 2006). Specifically, a complementary simultaneous mixed-method design was used where both the qualitative and the quantitative components of the study were independent in their own right (Creswell, 2013).

Morse (2000) used plus (+) sign to denote simultaneous mixed-method design. The dominant method is denoted with capital letters (e.g. QUAN for quantitative and QUAL for qualitative). The less dominant method is denoted with small letters (i.e. qual for qualitative and quan for quantitative). In the current study, both quantitative and qualitative component, were all dominant parts. The specific mixed method design used was therefore a complementary

simultaneous QUAN + QUAL design. The quantitative aspect of the study was first carried out followed by the qualitative study.

3.3 Sample Technique and Sample Size

In mixed-method studies, sampling is quite complex because as Onwuegbuzie & Collins, (2007) argue, sampling framework needs to be developed for both components of the study. Developing the right sampling schemes for selecting participants ensures analytical generalization in the qualitative part of the study while also ensuring statistical generalization in the quantitative part of the study (Cresswell, 2013; Onwuegbuzie & Collins, 2007).

In the current study, the parallel sampling technique developed for mixed-method studies was used (Onwuegbuzie & Collins, 2007). The parallel sampling technique is a way of selecting samples for a simultaneous mixed-method study that ensures that different samples are selected for different components of the study to ensure that no single participant takes part in both parts of the study (Onwuegbuzie & Collins, 2007). In the current study, different sets of participants were selected for the qualitative and the quantitative parts of the study.

In selecting the participants for the study, different sampling techniques were used. In both parts of the study, purposive sampling techniques were used to select participant based on the condition that they treat schizophrenia. As and when necessary, snow balling was also used to locate participants. The snow balling technique was mainly used in locating the non-professional practitioners because they practice in isolation and are spread wide apart from each other. Different sample size determinations were used in deciding how many practitioners were sampled for each component of the study. Below are how both quantitative and qualitative study were specifically carried out.

3.4 Study 1: Quantitative study

3.4.1 Research design for the Quantitative study

The data for the quantitative component of the study was collected using survey method. The survey method involved administering questionnaires to a large sample of the practitioners. The questionnaires contained scales that measured attitudes towards collaboration, stigma associated with schizophrenic care and attitudes towards patients with schizophrenia.

The choice of the survey technique was appropriate for this study because it allows for larger data set to be collected. For practitioners with high levels of education such as clinical psychologists, psychiatrists etc., the questionnaire was self-administered. Whilst with the non-professional practitioners such as herbalists, traditional priests etc. with low levels of education, the questionnaire was researcher-administered.

3.4.2 Study setting

The quantitative study was conducted in three regions in Ghana; Ashanti, Brong Ahafo and Greater Accra. These regions were used for the study because according to Ghana Statistical Service (GSS, 2013), two of the regions (Ashanti and Greater Accra) constitute the most populous region in the country which captures a majority. The Brong Ahafo region was included in the study because the region also has a large number of non-professional mental health practitioners including faith-based healers and traditional herbalists (de-Graft Aikins, 2002). These three regions therefore face a fair share of the treatment gap in mental health and serve as a fertile ground in exploring the issue.

Some practitioners were located in health facilities and others were located in communities and villages in the three regions. The health facilities visited were Accra Psychiatric Hospital,

Pantang hospital and Ussher Poly clinic all in Greater Accra region, Kintampo Health Centre in Brong Ahafo region and Komfo Anokye Teaching Hospital in Ashanti region. Some selected locations or places visited in the three regions included Accra, Kumasi, Tuobodom, Techiman, Kintampo, Oforikrom, Kokuma, Apesika, Kodie etc.

3.4.3 Population for the quantitative Study

With the quantitative study, the target population were professional mental health practitioners (psychologists and psychiatrists) and non-professional mental health practitioners (herbalists, religious leaders) operating within the three selected regions.

3.4.4 Quantitative Sample

With the quantitative study, the sample size was one hundred and ten practitioners (110). The sample size was determined to be adequate using Tabachnick and Fidell (1996) formula for determining the minimum sample size for multivariate analysis. They use the formula $N > 50 + 8M$ (where M = number of IVs). There were two main groups of interest; type of practitioners and gender. Therefore, there were two main independent variables and the minimum number of participants required was $N > 50 + 8(2) = 66$. The sample of 110 participants was therefore adequate for the current study. The demographic characteristics of the quantitative participants are summarized on Table 3.1.

Table 3.1: Demographic Characteristics of Survey Participants (N = 110)

Variables	Category	Frequency	Percentage
Gender	Male	72	65.0
	Female	38	35.0
Practitioner	Non-professional practitioners	60	55.0
	Professional practitioners	50	45.0
Type of Practitioner	Traditional priest	11	10.0
	Herbalist	8	7.0
	Mallam	9	8.0
	Prophet/pastor	32	29.0
	Clinical Psychologists	16	15.0
	Psychiatrist	8	7.0
	CPO	4	4.0
	Psychiatric nurse	22	19.0
Education	No education	8	7.0
	Primary	13	12.0
	JHS	25	23.0
	SHS	14	13.0
	Tertiary	50	45.0
Years of education	Mean = 11.37 years SD = 133 years		
Region	Ashanti	42	38.0
	Brong Ahafo	36	33.0
	Greater Accra	32	29.0
Ethnicity	Akan	81	74.0
	Ga	9	8.0
	Ewe	9	8.0

Table 3.1 Contd

Variables	Category	Frequency	Percentage
Religion	Mole-Dagbani	5	5.0
	Other	6	6.0
	Christianity	92	84.0
	Islamic	8	7.0
	African Traditional Religion	10	9.0
Marital status	Single	36	33.0
	Married	72	65.0
	Divorced	1	1.0
	Cohabiting	1	1.0

Table 3.1 shows that in terms of gender distribution, there were more males (65.0%) than female participants (35.0%). Slightly more than half of the respondents were non-professional practitioners (55.0%) and the rest were professional practitioners (45.0%). All the professional practitioners had tertiary education and the educational level of the non-professionals ranged between no education to senior high school.

3.4.5 Measures and Instruments

Different measures and instruments were used to gather data for the study. The quantitative data was gathered using standard scales that were put together to form a questionnaire.

3.4.6 Quantitative Measures

Three standardised scales were adapted to measure the variables in quantitative part of the study. Attitude towards collaborative care was measured by adapting the Attitude Towards

Collaboration Instrument (ATCI) developed by Van, Costa, Abbott, Mitchell, and Krass (2012). The original scale was developed to measure attitudes towards collaboration between pharmacists and general practitioners. The ATCI has 15 items measured on a five point Likert scale ranging from 1 = strongly disagree to 5 = strongly agree.

The ATCI has good internal consistency, with Cronbach alpha ranging from .93. Some items were modified to suit the context of mental health practitioners in Ghana. For example, an item like ‘I can trust the GP’s professional decisions’ was modified to “I can trust the non-professional practitioners’ decisions”. Modifications were done to suit both professional and non-professional practitioners.

Attitude Towards Patients with Schizophrenia was measured by adopting the Staff Attitudes Towards Patients with Schizophrenia scale developed by Vendsborg et al. (2013). The original scale was developed to measure stigmatizing attitudes have been reported in international studies among staff in psychiatry. The authors wanted to investigate if this was the case in Denmark. The ATPS is a 20-item scale measured on a 6-point Likert scale including “Strongly agree/agree/partly agree” and “partly disagree/disagree/strongly disagree” with some items that are reverse-scored. The scale has recorded a Cronbach alpha of .79 among medical doctors.

Stigma Toward Professionals who treat schizophrenia was measured by adopting The Stigma Scale: development of a standardised measure of the stigma of mental illness developed by (King et al., 2007). The original scale was developed to have a standardised instrument to measure the stigma of mental illness. It has 28 items measured on a five-point Likert scale ranging from “Strongly agree” to Strongly disagree” where “Strongly agree” =5, “Agree” = 4, “Neither agree nor disagree” =3, “Disagree” =2 and “Strongly disagree” = 1

It has three sub-scales: the first is about discrimination, the second disclosure and the third potential positive aspects of mental illness. The scale has a Cronbach alpha of 0.87.

The items were modified to suit the stigma experienced by mental health providers in Ghana. For example, an item like “Sometimes I feel that I am being talked down to because of my mental health problems” was modified to “Sometimes I feel that I am being talked down to by other health professionals because of my specialty in the care of patient with schizophrenia.

3.4.7 Procedures for Data Collection

Ethical clearance was first of all sought from the Ethic Committee for Humanities (ECH) of University of Ghana for approval to undertake the study. After that, an introductory letter was taken from the Department of Psychology to the study communities.

After the ethical approval was given, a pilot study was first conducted. The pilot study served the purpose of assessing the ability of the interview guide to elicit the right responses. Through the pilot study, any challenge(s) with the interview guide were corrected before proceeding with the main study. After the pilot study, the main study followed. This covered both aspects of the study.

3.4.8 Piloting the quantitative instruments

After the ethical approval, the quantitative questionnaires were piloted first. The piloting of the quantitative involved a survey of 15 participants comprising ten (10) professionally-trained mental health practitioners and five (5) non- professionally-trained mental health practitioners of which 8 of them were males and 7 of them were females. The data was analysed using statistical package for sciences (SPSS) software. Reliability analysis done on the three scales showed high Cronbach Alphas for all the scales.

3.4.9 The Main Study

The main study was undertaken after the pilot study. Participants who took part in the pilot study were not included in the main study. Recruitment of participants for the study was then carried out. In the process of recruiting participants for the study, as when necessary, some surveys were conducted. The data in Greater Accra was collected first before travelling to Ashanti region and then Brong Ahafo region. The entire data collection for the three regions took approximately two and a half months, starting in mid-January 2017 and ended in mid April 2017.

3.4.10 Ethical Consideration

The researcher maintained high ethical standards during the process of the study. The nature and purpose of the study was first explained to participants who were approached for the study. Those who agreed to participate were given the informed consent form to sign before taking part in the study. Again, participants were made aware of the voluntary nature of the study, their right to withdraw at any point in time without explanation or penalty. They were also assured of their privacy and confidentiality. After the study, the researcher addressed any other concerns that participants had about the study in the form of debriefing.

3.4.11 Quantitative Data Analyses

The quantitative data was analysed using multivariate statistical technique. Preliminary data analyses were conducted to check reliability of the scales and the normality of distribution of the scores. Factor analysis was also conducted to examine the underlying dimensions of the structures in the scales used. After the preliminary data analysis, multivariate technique was then used to test the hypothesis in the study. Multivariate analysis of variance (MANOVA)

was conducted to test the hypotheses. Further information on quantitative data analysis are provided in chapter 4.

3.5 Study 2: Qualitative study

3.5.1 Research design for qualitative study

Qualitative method was chosen as equally dominant method for the study because the issues being explored are issues that are highly debated and contested among practitioners (Shields et al., 2016). This requires in-depth engagement and discussions with practitioners in mental health delivery in Ghana to gain a deeper understanding. Qualitative approach offers the opportunity for such deeper exploration of a highly debatable and contested issue such as professional mental health practitioners and non-professional mental health practitioners working together.

Qualitatively, in-depth individual interviews were used for collecting data. In-depth interviewing in qualitative research involves collecting data through intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program or situation (Creswell, 2013). In-depth individual interview has been chosen ahead of other methods of gathering qualitative data such as focus group discussion, for two reasons.

The first reason is the depth of information that the current study seeks to gather about the issue. According to Boyce (2006), in-depth individual interviews are best suited when the researcher wants detailed information about a person's thoughts and behaviours or want to explore new issues in depth. It is also intended to provide a more complete contextual picture of a particular situation and why. The second reason for choosing individual in-depth

interviews is because of the nature of the study participants. Mental health practitioners (both professional and non-professional) are very busy people and therefore very difficult (if not impossible) to get them to gather for a focus group discussion. In view of this, individual in-depth interview is seen as the best approach to reach participants and enable them participate in the study at their convenient and feasible time.

3.5.2 Qualitative Sample

In determining the sample size for the in-depth interviews, several factors were taken into consideration. Factors such as the type of issue being explored, the kind of participants needed for the study, budget or resources available for the study, heterogeneity of the sample etc. (Morse, 2000; Ritchie et al., 2003).

Additionally, most studies use saturation as criterion in determining the sample size of individual in-depth interviews. Saturation point in qualitative research is collecting information from participants until no new information is coming up (Mason, 2010). However, a meta-synthesis conducted by Mason (2010) on PhD studies that used purely qualitative methods reported a mean sample size of 31. In the study, Mason has argued that a sample size of between 15 to 30 can be used to do in-depth exploration of an issue.

A minimum of 5 participants from each category of mental health practitioners were interviewed in this study. There are four main categories; professional mental health practitioners, herbalists, traditional priest and neo-prophetic pastors (Barimah & Akotia, 2015; Osafo, 2016).

Table 3.2: Demographic Characteristics of Interview Participants (N = 30)

Variables	Category	Frequency	Percentage	
Gender	Male	20	67.0	
	Female	10	33.0	
Practitioner	Non-professional practitioners	20	67.0	
	Professional practitioners	10	33.0	
Type of Practitioner	Traditional priest	6	20.0	
	Herbalist	6	20.0	
	Mallam	3	10.0	
	Prophet/pastor	5	17.0	
	Clinical Psychologists	2	7.0	
	Community mental health officers	1	3.0	
	Psychiatrist	4	13.0	
	Psychiatric nurse	3	10.0	
	Education	No education	7	23.0
		Primary	8	27.0
JHS		5	17.0	
SHS		2	7.0	
Tertiary		8	27.0	
Years of education	Mean = 9.03 years, SD = 1.24 years			
Region	Ashanti	13	43.0	
	Brong Ahafo	14	47.0	
	Greater Accra	13	43.0	
Religion	Christianity	16	53.0	
	Islamic	3	10.0	
	African Traditional Religion	11	37.0	

A total of 30 practitioners were interviewed for the qualitative part of the study. The demographic characteristics of the interview respondents are provided on Table 3.2. Majority of the practitioners interviewed were males and non-professional practitioners. Majority of them also had lower levels of education.

3.5.3: Measures and Instruments for qualitative study

A semi-structured interview guide was used for the individual in-depth interviews. The interview guide captured participants' views and opinions on two broad organising themes with their corresponding sub-themes. These are:

1. Representation of schizophrenia among lay mental health practitioners
 - Knowledge of schizophrenia
 - Source of knowledge
 - Functions of the knowledge (diagnostic and treatment practice)
2. Views and opinions on collaboration for schizophrenic care
 - Willingness to collaborate
 - Preference on collaborative models (cooperation, incorporation and total integration)
 - Challenges to collaboration
 - Ways of addressing the challenges

The semi-structured interview guide allowed for the same questions to be posed to all participants and probing questions to further explore the issue. Below is sample questions in the interview guide.

Table 3.3: Sample Questions in the Interview Guide

Understanding of mental illness among Lay Mental Health Practitioners

- i. How do you understand mental illness?
- ii. Where do you get all the knowledge you have on mental illness from?
- iii. How does your knowledge of mental illness influence your treatment practices for people with mental illness?
- iv. How do you diagnose schizophrenia?

Understanding of schizophrenia among Lay Mental Health Practitioners

- i. What do you know about schizophrenia?
- ii. Where do you get all the knowledge you have on schizophrenia from?
- iii. How do you diagnose schizophrenia?
- iv. How does your knowledge of schizophrenia influence your treatment practices for people with schizophrenia?

Views and Opinions on Collaboration for Schizophrenic Care

- i. What are your views and opinions concerning different practitioners collaborating to provide schizophrenic care?
 - ii. Which kind of collaboration will you be willing to work with and why?
 - iii. Which role would you want to be playing in the collaborative care?
 - iv. What challenges do you foresee in the attempt at collaborative care for dealing with schizophrenia?
-

3.7.1 The Pilot Study for qualitative study

After the ethical clearance was given, the pilot study was conducted to assess the interview guide. A total of four (4) practitioners involving two (2) professionally-trained mental health practitioners and two (2) non-professional mental health practitioners. The pilot interviews were transcribed and analysed to assess how well the interview guide elicited information. The questions on the interview guide was able to elicit the information needed except that there was a little challenge with regards to using the same words for the same questions when the questions had to be translated into “Twi” for the lay mental health practitioners who couldn’t speak English. This challenge was dealt with before proceeding with the main study by translating the interview guide into “Twi” language to ensure that the right and same questions are posed to the respondents who were not conversant with English language.

3.7.2 The Main Study for qualitative

Just as the quantitative study, the qualitative study was conducted after the pilot study with the data in Greater Accra being collected first before proceeding to Ashanti region and then finally to Brong Ahafo region. The entire data collection for the three regions took approximately two and a half months, starting in mid-January 2017 and ended in around the middle of April 2017.

3.7.3 Qualitative Data Analyses

Thematic analysis was used to analyse the data. All the interviews were audio recorded (with permission from participants) and transcribed for analyses. Two people helped with the transcription of the interviews. They were a PhD and and Mphil students with background in psychology and qualitative research methodology. Three other people with the same background were involved in the data analysis. Two of them were MPhil students and the other was a PhD student. The analysis was done on a round table where we had to agree or disagree

on themes and finally come to a consensus on a particular theme. For instance, to get a theme like transformed speech, one made mention of irrelevant speech and the other three agreed on transformed speech with the reason that by transformed speech the respondents meant any change in their speech after the illness. This change could be irrelevant, incoherent or illogical.

The coding and analyses were done in a six-stage process as proposed by Braun and Clarke (2006). The first stage involved reading and re-reading the transcripts to make sense of the broad themes within the narratives. The transcription process was a major means of establishing familiarisation with the data. The data that were transcribed by others were checked back against the original audio to ensure correctness of the information provided.

The second stage involved getting the initial codes from the data. According to Tuckett (2005) this phase ensures that the data is organised into meaningful groups. In this study, coding was done across the two organizing themes with regards to schizophrenia schizophrenic care;

(1) Representation of schizophrenia among lay mental health practitioners

- Knowledge of schizophrenia
- Source of knowledge
- Functions of the knowledge (diagnostic and treatment practice)

(2) Views and opinions on collaboration for schizophrenic care

- Willingness to collaborate
- Preference on collaborative models (cooperation, incorporation and total integration)

- Challenges to collaboration
- Ways of addressing the challenges

The third stage involved refining codes and themes within the practitioners across the two broad thematic areas by noting areas of consensus, conflict and absence. The fourth stage involved refining codes and themes across professional and non-professional groups under the two broad thematic areas by noting areas of consensus, conflict and absence.

The fifth stage involved working out cross-professional inter-sections by examining the nature of themes running through all narratives around which ideas and opinions on integrative treatment of schizophrenia converge or diverge among the practitioners. At this level, analyses of cross-professional collaboration were examined.

The final stage involved reporting what the data entailed. At this stage an account of what the data involved was given. Also adequate evidence of the various themes was given by pointing out quotes that speak to their respective themes. Further information on the qualitative data analysis are provided in chapter 4.

CHAPTER FOUR

RESULTS

4.1 Introduction

The current study basically sought to examine views and opinions about the different collaborative frameworks between professional and non-professional mental health practitioners using schizophrenic care in Ghana as a case study. The study combined a mix of qualitative and quantitative methods simultaneously to examine the dynamics of collaborative care for schizophrenia in Ghana between professional and non-professional mental health practitioners.

Study 1 (the quantitative component of the study) tested some hypotheses regarding collaborative care between professional and non-professional mental health practitioners within the context of schizophrenic care in Ghana. Three fundamental objectives were addressed here: (i) examined attitudes towards collaborative care for schizophrenia among the professional and lay mental health practitioners (ii) measured attitudes toward patients with schizophrenia among the lay mental health practitioners and (iii) assessed the level of stigma experienced between professional and non-professional mental health practitioners within the context of schizophrenic care in Ghana.

Study 2 (the qualitative component of the study) had two fundamental objectives; (i) explored the understanding of schizophrenia among the non-professional practitioners and how their understanding influenced their diagnosis and treatment of schizophrenia, (ii) explored their

views and preferences for the different collaborative frameworks for schizophrenic care between professional and non-professional mental health practitioners.

This chapter presents detailed findings from both the quantitative and the qualitative components of the study. For the purposes of clarity, the findings from study 1 (the quantitative component of the study) are presented first, followed by findings from study 2 (the qualitative component). After that, a chapter summary is presented that summarizes all the findings from both the qualitative and the quantitative components.

4.2 Study 1: Quantitative Results

This sub-section presents analysis and results of the quantitative data. Preliminary analyses were first conducted before testing the hypotheses in the study.

4.2.1 Preliminary Data Analysis

This sub-section contains all preliminary analyses that were conducted on the data to prepare the data for inferential statistical analyses to test the hypotheses. Among the preliminary analysis conducted here were checking the reliability of the scales, assessing normality of the data distribution and examining group differences in the variables measured in the current study.

4.2.2 Descriptive Statistics, Normality and Reliability of Variables

The reliability levels of the scales were analysed using Cronbach alpha coefficient. According to Tashakkori and Teddlie (2010), for a scale to be considered reliable, the reliability coefficient should be above 0.70.

After assessing the reliability of the scales, the normality of the data was also examined to ensure that the data were normally distributed. The normality of the data was assessed using

skewness and kurtosis, by running descriptive statistics. Tabachnick and Fidell (2007) state that a data is said to be normally distributed when the skewness values lie within the range of between +1.00 and -1.00 and the kurtosis values lie within the range of between +2.00 and -2.00.

The data was also examined to check the presence of outliers and it was observed in the output that no multivariate outliers were present. Again, residuals were examined to check the spread of individual scores and how the variables relate to each other. The results indicated that there were no problems of linearity and homoscedacity and were all within the range of -3 to +3 (Tabachnick & Fidell, 2007). Table 4.1 shows the summary of the preliminary analyses of the data.

As shown on Table 4.1, the Cronbach alpha coefficient values range between $\alpha = .804$ and $\alpha = .879$. This means that all the scales had high reliability levels. The skewness values lie between -.769 and .756 and the kurtosis values lie between -.560 and 1.776. Because all the values for skewness and kurtosis are within the acceptable limit, it shows that the data was normally distributed.

Table 4.1: Summary of Means, SD, Reliability, Skewness and Kurtosis of Variables

Variables	M	SD	A	Skewness	Kurtosis
Attitude towards Schizophrenic Patients	62.10	15.84	.805	-.062	-.560
Stigmatizing Attitudes	18.88	8.93	.801	-.535	-1.445
Supportive Attitudes	9.17	3.94	.793	.185	1.364
Discriminating Attitudes	9.57	3.19	.778	-.150	-.593
Attitude towards Collaborative Care	50.97	11.36	.879	-.671	-.121
Competence Recognition	25.75	7.54	.786	-.263	-.772
Open Communication	20.45	4.84	.856	-.831	.306
Stigma associated with schizophrenic care	62.17	15.80	.807	-.065	-.555
Discrimination	28.36	9.95	.812	.756	.094
Disclosure	25.04	4.17	.801	-.408	.502
Positive	16.34	3.39	.804	-.769	1.776

N = 110, S.E of Skewness = 0.309, Kurtosis = 0.608

4.2.3 Test of Hypotheses

This sub-section presents the findings from the hypotheses that were tested in the study.

4.2.4 Group Differences in Attitude towards Collaborative Care

A One-way MANOVA was used to test for mean differences in attitude towards collaborative schizophrenic care, measured as competence recognition and open communication. The groups included in the analysis were practitioners (professionals and non-professionals) and gender (male and females). The results are summarized on Table 4.2.

Table 4.2: Summary of MANOVA results for Attitude towards Collaborative Care

	Type of practitioner		Df	F	P	η^2
	<u>Non-Professional</u>	<u>Professional</u>				
	N=60 M(SD)	N=50 M(SD)				
Collaborative Care						
Competence recognition	23.43(7.55)	28.65(6.53)	1,108	14.684	.000	.120
Open Communication	18.21(4.96)	23.24(2.88)	1,108	39.664	.000	.269

Table 4.2 shows mean differences in the two components of attitudes towards collaborative care between professional and non-professional mental health practitioners. For the two components of the attitudes, the Wilk's Lambda [$\lambda = .719$, $F(2, 107) = 20.893$, $p < .001$] indicates a significant multivariate effect, with a medium effect size ($\eta^2 = .281$).

There is a significant means differences in both competence recognition [$F(1, 108) = 14.684$, $p < .001$, $\eta^2 = .120$] and open communication [$F(1, 108) = 39.664$, $p < .001$, $\eta^2 = .269$] among the practitioners. Comparing the mean scores, the findings indicate that professional mental health workers have significantly higher competence recognition ($M = 28.65$, $SD = 6.53$) than the non-professional practitioners ($M = 23.43$, $SD = 7.55$). The professional practitioners also recorded higher score on open communication ($M = 23.24$, $SD = 2.88$) than the non-professional practitioners ($M = 18.21$, $SD = 4.96$).

Putting it all together, the findings show that compared to the non-professionals, the professional practitioners recognise the competence of the non-professional practitioners and also more willing to let information flow between them. This means that the professional

practitioners have more positive attitudes towards collaborative schizophrenic care than the non-professional attitudes.

4.2.5 Group Differences in Stigma Associated with Schizophrenic Care

Differences in stigma associated with schizophrenic care were also assessed. Three sub-scales of stigma were used as dependent variables; discrimination, disclosure and positive aspects. The results of the MANOVA analysis are summarized on Table 4.3.

Table 4.3: Summary of MANOVA results for Stigma Associated with Schizophrenic Care

Stigma	Type of practitioner		Df	F	P	η^2
	<u>Non-Professional</u> N= 60 M(SD)	<u>Professional</u> N=50 M(SD)				
Discrimination	23.79(7.47)	34.06(9.76)	1,108	39.09	.000	.266
Disclosure	25.23(3.95)	24.80(9.95)	1,108	.291	.591	.003
Positive Aspect	17.07(2.93)	15.43(3.72)	1,108	6.6	.011	.058

Table 4.3 shows mean differences in the three components of stigma associated with schizophrenic care between professional and non-professional mental health practitioners. The Wilk’s Lambda [$\lambda = .652$, $F(3, 106) = 18.835$, $p < .001$] indicates a significant multivariate effect, with a medium effect size ($\eta^2 = .348$).

The results show significant mean differences in two aspects of stigma associated with schizophrenic care among the practitioners; discrimination [$F(1, 108) = 39.09$, $p < .001$, $\eta^2 = .266$] and positive aspect [$F(1, 108) = 6.66$, $p < .05$, $\eta^2 = .058$].

Comparing the mean scores, the findings indicate that professional mental health workers experience significantly higher discrimination ($M = 34.06$, $SD = 9.76$) than the non-

professional practitioners ($M = 23.79$, $SD = 7.47$). The professional practitioners also recorded low score on positive aspect ($M = 15.43$, $SD = 3.72$) than the non-professional practitioners ($M = 17.07$, $SD = 2.93$).

Putting these observations together, the findings show that professional mental health practitioners experience higher discrimination and lower positive aspect of stigma compared to their non-professional counterparts. This means that in Ghana, professional mental health practitioners experience higher levels of stigma associated with schizophrenic care than non-professional mental health practitioners.

4.2.6 Group Differences in Attitudes towards Patients with Schizophrenia

Differences in attitudes towards patients with schizophrenia were also examined among the four groups of the non-professional mental health practitioners using One-way MANOVA. Three components of attitudes towards patients with schizophrenia were assessed; stigmatizing attitudes, supportive attitudes and discriminating attitudes. These three attitudes were compared among traditional priests, herbalists, mallams and neo-prophets. The results are provided on Table 4.4.

Table 4.4: Summary of MANOVA results for Attitudes towards Patients with Schizophrenia

	Stigmatization	Supportive	Discrimination
Non-Professionals	M(SD)	M(SD)	M(SD)
Traditional Priests	15.91(8.76)	7.36(2.06)	8.18(2.40)
Herbalist	19.50(10.81)	6.88(2.74)	10.00(2.73)
Mallam	20.88(8.44)	8.00(2.45)	9.63(2.62)
Neo-prophet	19.24(8.93)	10.61.(4.40)	9.91(3.19)
<i>df</i>	<i>3,54</i>	<i>3,54</i>	<i>3,54</i>
<i>F</i>	<i>.557</i>	<i>3.871</i>	<i>.861</i>
<i>p</i>	<i>.646</i>	<i>.014</i>	<i>.467</i>
<i>η²</i>	<i>.029</i>	<i>.172</i>	<i>.044</i>

Table 4.4 shows mean differences in the three components of attitudes towards patients with schizophrenia among the four groups of non-professional mental health practitioners. Wilk's Lambda [$\lambda = .789$, $F(3, 54) = 3.892$, $p < .05$] indicates a significant multivariate effect, with a small effect size ($\eta^2 = .172$).

The results show significant mean differences in only one aspects of attitudes towards patients with schizophrenia; supportive attitude [$F(3, 54) = 3.871$, $p < .05$, $\eta^2 = .172$]. A multiple comparison of the mean differences, using Tukey test shows that the neo-prophets scored significantly highest on supportive attitudes towards patients with schizophrenia ($M = 10.61$, $SD = 4.40$) than the other three groups. This means that the neo-prophets had more positive or supportive attitudes towards patients with schizophrenia, compared to other non-professional mental health practitioners

4.2.7 Exploratory Factor Analysis for the Construct Validity of Scales

An exploratory factor analyses were first conducted using Principal component analysis (PCA) to test for the construct validity of the adapted scales within the Ghanaian context. The function was to ascertain whether individual items in each of the scales would load meaningfully onto the underlying factor structure of the scales (Pallant, 2010). All the assumptions of factor analysis were checked to ensure that the data was suited for factor analysis.

4.2.8 Exploratory Factor Analysis of Attitude towards Patients with Schizophrenia Scale

The 20 items of the Attitude towards Patients with Schizophrenia (ATPS) Scale were subjected to principal components analysis (PCA). Evaluation of the correlation matrix showed that all the items had coefficients above .30. The Kaiser-Meyer-Oklin value was found to be approximately .73, which exceeds the minimum recommended value of .60 (Kaiser, 1974). The Barlett's Test of Sphericity was also found to be significant ($\chi^2 = 1404.615$, $p < .001$), which supported the factorability of the correlation matrix (Bartlett, 1954).

The components analysis showed the presence of seven components with eigenvalues more than 1, explaining 27.313%, 14.538%, 10.926%, 9.381%, 6.546%, 5.742% and 5.427% respectively. However, evaluation of the scree plot showed that the components levelled off after the third factor. Therefore, based on Catell's (1966) scree test, three components were retained for further investigation. Test of Parallen Analysis using the Monte Carlo PCA showed the three factors with eigenvalues exceeding the corresponding criterion values for a randomly generated data matrix of the same size (20 variables \times 110 respondents).

A varimax rotation then showed the three factors having clear pattern matrix with strong loadings where all items loaded clearly on all three. The three components explained a total variance of 52.776%, with component 1 explaining 27.313%, component 2 explaining 14.538% and component 3 explaining 10.926%. The interpretations of the three component was somehow consistent with previous studies that have used the ATPS scale. Two items in the current study however loaded positively on component 2 and negatively on component 3 simultaneous. The three factors are described below:

Table 4.5 (Factor 1): Stigmatizing Attitude sub-scale

Items	Loadings
1. People with schizophrenia can never reach a good quality of life.	.975
2. People with schizophrenia are dangerous more often than not	.508
3. The public does not need to be protected from people with schizophrenia	.975
15. I just learn about mental health when I have to, and would not bother reading additional material on it	.976
17. I use terms like crazy, mad etc. to describe people with schizophrenia who I see in my work	.966
<i>% variance explained</i>	27.313%,

The stigmatizing attitudes factor examines attitudes that stigmatize people with schizophrenia. Five items loaded strongly on this factor. This is consistent with the original scale.

Table 4.6 (Factor 2): Supportive Attitude sub-scale

Items	Loadings
9. Schizophrenia is primarily set off by a combination of the mentioned factors	.400
11. The way I see patients with schizophrenia influences my opinion about the possibility for recovery	.594
12. It is important that if I am supporting a person with schizophrenia I have to also assess their physical health	.861
13. It is important that any health/social care professional supporting a person with schizophrenia also ensures that their physical health is assessed	.818
16. I feel as comfortable talking to a person with schizophrenia as I do talking to a person with a physical illness.	.596
<i>% variance explained</i>	<i>14.538%</i>

The supportive attitude measures attitudes that healers hold about schizophrenic patients that support their care and recovery or rehabilitation. Five items loaded strongly on this scale as it was expected from the original scale.

Table 4.7 (Factor 3): Discriminating Attitude sub-scale

Items	Loadings
6. Schizophrenia is set off primarily by relations in the family	.437
18. If a colleague told me he or she had schizophrenia, I would still want to work with him or her	.801
19. If I had schizophrenia, I would never admit this to my colleagues for fear of being treated differently	.976
20. If I had schizophrenia, I would never admit this to any of my friends because I would fear being treated differently	.772
<i>% variance explained</i>	<i>10.926%</i>

The discriminating attitude factor measures the kind of attitudes that suggest segregation and isolation of people with schizophrenia from the healthy population. Five items were expected to load to this factor. However, only four items loaded strongly. The remaining one item (People with schizophrenia need to be put away) did not load to this factor or any other factor. Perhaps this item did not make sense to the respondents.

4.2.9 Exploratory Factor Analysis of Stigma towards Practitioners Who Treat Schizophrenia Scale

The 28 items of the Stigma towards Professionals who Treat Schizophrenia (STPS) scale were subjected to principal components analysis (PCA). Evaluation of the correlation matrix showed that all the items had coefficients above .30. The Kaiser-Meyer-Okin value was found to be approximately .789. The Barlett's Test of Sphericity was also significant ($\chi^2 = 2203.819$, $p < .001$).

The components analysis showed the presence of eight components with eigenvalues more than 1, explaining 24.801%, 13.498%, 7.442%, 6.133%, 5.121%, 4.983%, 4.471% and 3.575% respectively. Evaluation of the scree plot showed that the components levelled off after the third factor. Therefore, three components were retained for further investigation.

A varimax rotation showed the three factors have clear pattern matrix with strong loadings. The three components explained a total variance of 45.741%, with component 1 explaining 24.801%, component 2 explaining 13.498% and component 3 explaining 7.442%. The interpretations of the three components were somehow consistent with previous studies that have used the STPS scale. The three factors are described below:

Table 4.8 (Factor 1): Discrimination Sub-scale

Items	Loadings
1. Sometimes I feel that I am being talked down to by other health professionals because of my specialty in the care of patient with schizophrenia	.556
6. I have been discriminated against by other health professionals because of my specialty in schizophrenic care	.667
7. People have insulted me because of my care for patients for schizophrenia	.688
9. I am angry with the way other colleagues have reacted to professionals who treat schizophrenia	.620
10. I have been discriminated against in education because I treat schizophrenia	.703
11. Sometimes I feel that I am being talked down to because I give schizophrenic care	.509

Table 4.8: Contd

Items	Loading
24. I have been discriminated against by other health professional because I give schizophrenic care	.679
3 I have been discriminated against by my employers because of my specialty in schizophrenic care	.787
2. I do not feel bad about specializing in schizophrenic care	.416
13. I do not feel bad about having chosen to give schizophrenic care	.626
14. Some people with schizophrenia are dangerous	.515
15. I have been discriminated against by police because I give schizophrenic care	.576
16. Treating people with schizophrenia has made me more accepting of other people	.717
25. Having treated people with schizophrenia has made me a stronger person	.421
<i>% variance explained</i>	24.801%

The discrimination factor measures both direct and indirect discriminations that practitioners experience because of their association with the treatment of schizophrenia. A total of 14 items loaded strongly onto this factor which is consistent with the expected number of loadings from the original scale.

Table 4.9 (Factor 2): Positive Aspect Sub-scale

Items	Loadings
5. Other people have never made me feel embarrassed because of my care for patients with schizophrenia	.781
12 Having given schizophrenic care has made me a more understanding person	.444
23 I have not had any trouble from people because of my care of schizophrenia	.706
<i>% variance explained</i>	13.488%

The positive aspect factor measures the positive experiences of practitioners associated with schizophrenic care. Three items loaded onto this factor instead of five items as expected from the original scale.

Table 4.10 (Factor 3): Disclosure Sub-scale

Items	Loadings
4 I worry about telling people I give psychological treatment of schizophrenia	.497
8 I feel the need to hide my care of schizophrenic patients from my friends.	.590
17 I do not mind people in my neighbourhood knowing that I treat people with schizophrenia	.471
18 I am scared of how other people will react if they find out that I give schizophrenic care	.630

Table 4.10 Contd

Items	Loadings
20 I do not mind people in my neighbourhood knowing that I treat people with schizophrenia	.442
<i>% variance explained</i>	7.422%

This disclosure factor measures willingness of practitioners to disclose their identities within the context of having expertise in treating schizophrenia. Five items loaded strongly on this factor. It is expected that high score on the disclosure sub-scale would mean that the practitioners do not mind disclosing their identities or that the practitioners do not hide their identities of treating people with schizophrenia.

4.2.10 Exploratory Factor Analysis of Attitude towards Collaboration Instrument

The 15 items of the Attitude towards Collaboration Instrument (ATCI) were subjected to principal components analysis (PCA). Evaluation of the correlation matrix showed that all the items had coefficients above .30. The Kaiser-Meyer-Okin value was found to be approximately .825. The Barlett's Test of Sphericity was also significant ($\chi^2 = 753.466$, $p < .001$). The components analysis showed the presence of three components with eigenvalues more than 1, explaining 38.019%, 13.472% and 8.289% respectively. Evaluation of the scree plot showed that the components levelled off after the second factor. Therefore, two components were retained for further investigation.

A varimax rotation showed the three factors have clear pattern matrix with strong loadings. The two components explained a total variance of 51.491%, with component 1 explaining

38.019% and component 2 explaining 13.472%. The interpretations of the two components were somehow consistent with previous studies that have used the ATCI scale. The two factors are described below:

Table 4.11 (Factor 1): Competence Recognition Sub-scale

Items	Loadings
3 Lay mental health practitioners also deliver some level of quality healthcare to schizophrenic patients	.654
5 Lay mental health practitioners meet the lay expectations I have of them to some extent	.438
6 I can trust the lay mental health practitioners' decisions on schizophrenic care	.820
7 Lay mental health practitioners actively address schizophrenic patients' treatment concerns	.833
8 Discussions with lay mental health practitioners help me provide better patient care	.694
10 Lay mental health practitioners and I share common goals and objectives when caring for schizophrenic patient	.603
11 My role and the lay mental health practitioners' role in patient care are clear	.620
12 I have confidence in the lay mental health practitioners' expertise	.767
<i>% variance explained</i>	38.019%

The competence recognition factor examines willingness of practitioners to respect and recognize the expertise of the other practitioners. For instance, whether professional mental health practitioners would respect and recognize the expertise of non-professional practitioners

for the purpose of collaborating for schizophrenic care. A high score on this factor indicates a more positive attitude towards collaborative care.

Table 4.12 (Factor 2): Open Communication Sub-scale

Items	Loadings
1 The communication between myself and lay mental health practitioners is open and honest	.475
2 Lay mental health practitioners are open to working together with me on patients' schizophrenia management	.406
4 I make time to discuss with lay mental health practitioners on matters relating to schizophrenic patients' treatment regimens	.535
9 Lay mental health practitioners and I have mutual respect for one another on a lay level	.580
13 Lay mental health practitioners believe that I have a role in assuring treatment safety	.866
14 Lay mental health practitioners believes that I have a role in assuring treatment effectiveness	.807
<i>% variance explained</i>	13.472%

The open communication sub-scale examines how open practitioners are with one another and how easily information flow between them. Six items loaded on to this factor. A higher score indicates a more open communication which signifies a positive attitude towards collaborative care for schizophrenia.

4.2.11 Summary of Findings from Study 1

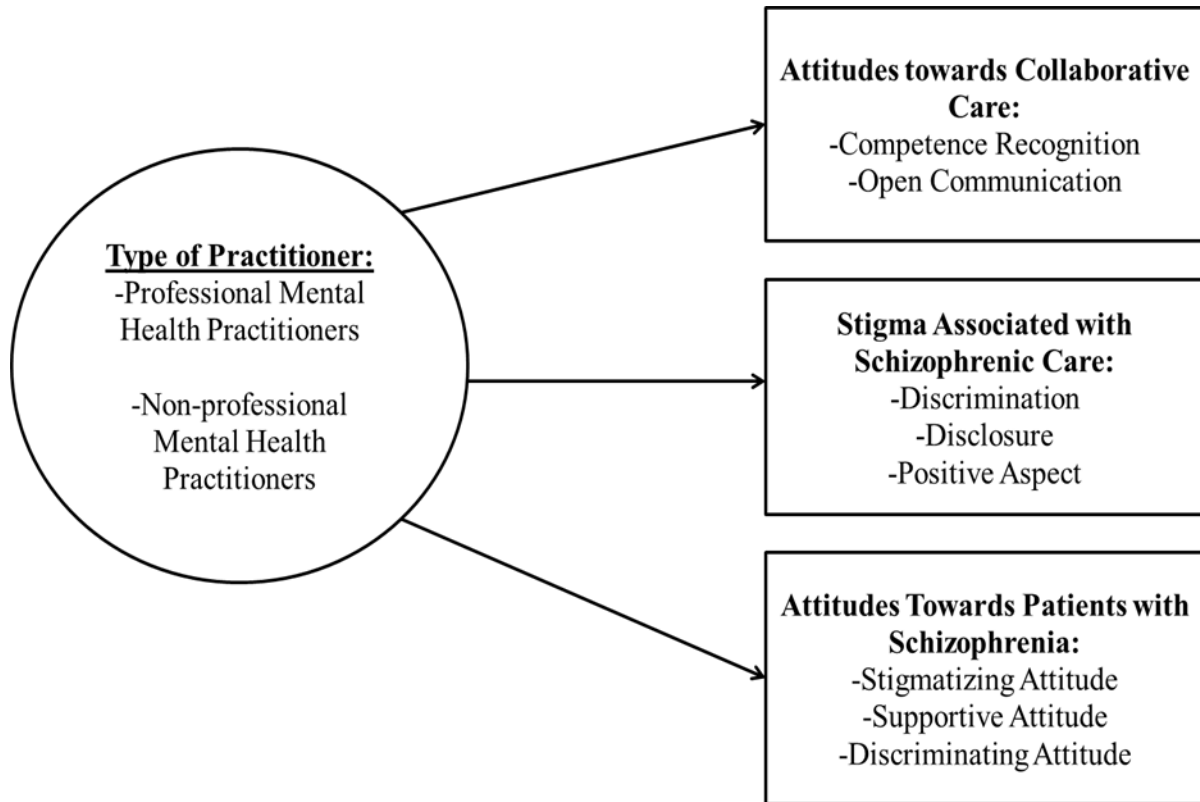
The quantitative data has shown that;

1. Professional practitioners have more positive attitudes towards collaborative schizophrenic care than the non-professional attitudes.
2. Professional mental health practitioners experience higher levels of stigma associated with schizophrenic care than non-professional mental health practitioners.
3. Neo-prophets had more positive or supportive attitudes towards patients with schizophrenia, compared to other non-professional mental health practitioners.

4.2.12 Observed Model for Study 1

In the observed model, principal component factor analyses showed two components for attitudes towards collaborative care (competence recognition and open communication), three components of stigma associated with schizophrenic care (discrimination, disclosure and positive aspect) and three components of attitudes towards collaborative care (stigmatizing attitude, supportive attitude and discriminating attitude). Significant group differences were observed among professional and non-professional mental health practitioners on these components.

Figure 2: Observed Model for Factors Associated with Schizophrenic Care



4.2.13 Brief Interpretations of Study 1

The findings from study 1 have showed largely, different practitioners in mental health care in Ghana experience schizophrenic care differently. First of all, the professional mental health practitioners experience more stigma associated with schizophrenic care than non-professional practitioners. This stigma manifests in the form of high feeling of discrimination towards professional practitioners and a high sense of pride for non-professional practitioners for their schizophrenic care. Secondly, despite experiencing higher stigma, the professional practitioners show more positive attitudes towards collaborating with non-professional practitioners for providing collaborative schizophrenic care in Ghana. This manifest in the form of the professional practitioners reporting higher recognition of the competence of the non-

professional practitioners and also being willing to have open communication compared to the non-professional practitioners.

The non-professional mental health practitioners held different attitudes towards patients with schizophrenia. This mainly manifests in terms of supportive attitudes where the pastors were found to report significantly highest supportive attitudes toward patients with schizophrenia compared to the others. This means that compared to the other non-professional practitioners, pastors are less likely to abuse patients with schizophrenia in the course of providing care for them.

4.3 Study 2: Qualitative Findings

The qualitative findings are presented based on the fundamental research questions that were raised. First of all, the qualitative analysis answered the question of ‘how do non-professional mental health practitioners understand schizophrenia and how their understanding of schizophrenia shape their diagnostic and treatment do practices? Secondly, ‘what are the views and perspectives of professional and non-professional mental health practitioners on collaborative schizophrenic care in Ghana? These two fundamental research questions guide the presentations of the qualitative findings.

Research Question1:

How do non-professional mental health practitioners understand schizophrenia and how do their understanding of schizophrenia shape their diagnostic and treatment practices?

The presentations of findings on this research questions are divided into two; the representations of schizophrenia among the non-professional practitioners are presented first before their diagnostic and treatment practices.

4.3.1 Representations of Schizophrenia among Non-professional Mental Health

Practitioners

The representations of schizophrenia among the non-professional practitioners were marked by mainly using patterns of symptoms. The dominant word they used to describe schizophrenia translates as ‘complete madness’. According to them someone can be mentally ill but not ‘completely mad’. Terms like “adwenmu ka” or “adwenmu haw” and “ɛdam” are used to differentiate between other forms of mental illness and schizophrenia respectively in the Twi language among the participants. Lay mental health practitioners mainly understand schizophrenia by using the symptoms that their patients they have diagnosed with schizophrenia exhibit. Three overarching themes emerged concerning the symptoms patients with schizophrenia exhibit; transformed speech, transformed behaviour and lack of awareness of their state of being. Each of these symptoms are described and interpreted below.

Transformed Behaviour

They further indicated that people with schizophrenia have transformed behaviours. They explained this to mean that the main distinction between normal people and those with schizophrenia is that when people get schizophrenia, their behaviours transform to become abnormal. Thus, people with schizophrenia behave as if they are in a different world and nothing they do makes sense. This was said by all the 20 lay mental health practitioners. Among some statements the respondents used are;

“The obvious traits which will be when such a person whom you may or may not have close acquaintance with will be acts are contrary from the usual acts of yours. That is what will make you know that such a person has gotten to a different state. Also, you

will be exposed to certain acts that are quite different from the usual by especially someone you live together with” (Male, Mallam, 20 years of practice).

*“Their behaviour become very awkward and haphazard with respect to their deeds...the person even talks to himself even if they are having a conversation with someone else.”
(Male, 15 years of practice, Traditional priest).*

Transformed Speech

The non-professional mental health practitioners indicated that their understanding of schizophrenia is marked by a state where individuals’ sense of speech changes from the normal to the abnormal. The main narratives used to describe this situation are that their speech change in form or transforms. Thus, people with schizophrenia no longer speak in a logical manner but they speak in ways that people around them do not understand. 19 out of the 20 lay mental health practitioners made mention of this. Sample quotes from respondents are:

“You will further observe that his or her speech has transformed. That is the difference I am talking about (Male, Mallam, 20 years of practice).

It’s when is there is no consistency in his or her speeches as well as thoughts. This is an indication by which someone can be described as being mentally ill... yes when there are lots of inconsistencies in their speeches. That will give an indication that such a person needs to undergo some form of treatment to recover” (Male, pastor 11 years of practice).

Loss of Awareness of State of Being

The non-professional practitioners indicated further that also know that individuals with schizophrenia lack awareness of their sense of being. Thus, people with schizophrenia lose their awareness of themselves and a sense of who they are or what role they play in society. 16 lay practitioners shared this idea. Below are sample quotes from the respondents:

“When one goes mad, the mad person doesn’t know he/she is mad and that is difficult to treat. If you understand or know you have such illness, it makes treating it very easy. Is like a sick person who claims he is healthy; how would such a person take the drugs you give him? Those that are mad don’t know that they are mad and think they are sane” (Male, Pastor, 5 years of experience).

“Persons with such effects are not also aware of their physical state of condition” (Male, Mallam, 11 years of practice).

Categories of Schizophrenia

The researcher explored further to find out whether there exist categories with regards to the schizophrenia cases that the non-professional practitioners deal with. Narratives from the respondents indicated that they categorise different kind of schizophrenia based on the perceived causes. In this regard, three major categories emerged; those that are as a result of family tensions, those that are as a result of a curse and those that are as a result of genetic.

Category one: Schizophrenia Originating from family tensions

The practitioners indicated one category of schizophrenia is the type that originates from family tensions. They indicated that sometimes a family member can buy schizophrenia in the spiritual realm for another family member. This usually comes as a result of family tensions or enmity among close family relations where one might feel jealous or cheated. This kind of schizophrenia is thought to have sudden on-set, very devastating, characterized by high aggression and have late onset. Thus, because individuals are not born with such conditions, it comes in later life and is very sudden. It causes such patients to behave very violently and aggressively. 10 lay practitioners shared this idea.

“To my knowledge, there are those originating from family issues, others are also of mental physique. With that of originating from family issues can be as a result of some pertinent problems or crises which cannot be handled by such persons. This can further lead to worry which will make a person pace back and forth muttering away to themselves and issuing threatening words. This they will stop upon realising the presence of someone” (Male, Mallam, 20 years of practice).

“For instance, there is a lady who lived with her mother and her mother’s husband. It got to a time that the girl was sharing bed with her step-father. The girl fought her mother anytime the mother talked about it. The mother bought a salt that it should be used to prepare food for the man, when the girl tasted it she got mad. She got mad for 8 years” (Male, pastor, 31 years of practice).

Category two: Schizophrenia originating from family genetics

The second category that emerged is the kind of schizophrenia which has genetic basis. The respondents indicated that this form of schizophrenia starts very early and is not easily cured compared to the others. 15 lay practitioners made mention of this. Some of their quotes are:

“There are some of them that are blood related. I know someone who is mad and her mother too is mad so for this it is in their blood line so they are taken to Pantang and are put on medication. When the effect of the drug finishes in the person, the illness comes back again” (Male, pastor, 31 years of practice).

“Sometimes it might be caused by someone. At other times too it could be as a result of genetics. It can be in the blood of...there is a woman who lives just about four houses away from us, she got mad and now two of her sons too are mad, one of the boys left this town and he has come back now”. (Male, Traditional priest, 19 years of practice).

Category three: Schizophrenia originating from a Curse

The third category of schizophrenia that emerged was the kind that arises from a curse from a stranger or someone outside the patient’s family. The respondents indicated that sometimes people can offend others (e.g. steal their properties, cheat them, insult them, cheat on someone’s wife or husband etc.) and the aggrieved person might curse them. When those cursed do not die, it can turn into ‘madness’. Sometimes too the aggrieved person specifically curse them with “madness” This category is found to be very common among young people between the ages of 20 – 35 years and is predominantly among males and it was shared by 18 lay practitioners.

“People go mad because of blood covenant. In Akan an oath is called ‘nsewdi’, swearing an oath, do you understand? Which tribe are you? Ans: I am an Akan. You see. So anyone who is overcome by that covenant tend to bear the consequences. Something like cursing, some people can pour the blood of an animal into a glass.....pour schnapps on it. So just as you are in school like this you will be in relationship for sometime and when you later on meet another person whom you are interested in, you tend to forget the oath you took with the person sometimes back. No curse kills faster than cursing whiles you are naked. Whatever you say come to pass. So once you the woman and the man have taken an oath and even slept with him, there is a spirit that comes to dwell in you. So when you break up in such relationship it can affect you (Male, Pastor 31 years of practice).

“mental illness could be caused by so many things. For example, being cursed by someone as a result of theft cases or having an intimate relationship with a married person” (Male, traditional priest, 15 years of practice).

Diagnosis

The study further explored diagnostic practices of schizophrenia among the non-professional practitioners. Thus, given their understanding of schizophrenia and how it comes about, the researcher inquired further into the various ways that the practitioners diagnose individuals brought to them as having schizophrenia.

Narratives from the respondents indicated that they use a complex set of practices in diagnosing whether an individual has schizophrenia or not. The major themes that emerged from the

respondents' narratives were information from family, observation, bodily examination and seeking spiritual insight.

Information from family and the patient

This theme came from all the categories of non-professional mental health practitioners. The respondents indicated that the first diagnostic activity they engage in is to interrogate the sick person in order to know their mental state and also listen to the family members or those who brought the patient. From their narratives it was clear that these lay mental health practitioners do not just ask any information but relevant clinical history including taking note of non-verbals which is not different from what a professional might ask. The information taking phase helps the practitioners to gain an insight into what might be happening to the person and what the family members think might have caused their relative's situation. Some of the sample quotes from the participants are indicated below:

“By asking questions through conversations and picking up certain cues or responses from the patient. For example, you may ask the individual how are you, he responds I am fine, you proceed with further questions to ask whether he is able to sleep then the person confirms he is able to sleep very well, then the same person when asked of the duration, the patient claims he slept around 8PM and woke up around 8:30 pm. this response would tell you that the person isn't in his right mind.

You could also ask if the individual constantly hears noises. Then the person confirms of hearing people talking to disturb him all the. You could also ask if the individual has eaten and the response would be that he last ate almost a week ago. The person feels free talking or conversing but he would be noting down the responses after which he

talks to the guardian or parents of the individual about the treatment procedures. For me I am not a soothsayer, I give herbal medicine to treat the mental illness so I advise that if they could comply with the medications everything will be alright". (Male, Herbalist, 12 years of practice).

"We do enquire from the person who brought the patient and later let the person become a representative during the time of prayer. Later upon recovery, the patient may further confess any other sins so that he can be prayed for" (Male, pastor, 28 years of practice).

Observation

The respondents indicated that the next diagnostic activity they engage in is observation. This theme also came from all the categories of the non-professional mental health practitioners. A total of 17 non practitioners made mention of this. They indicated that they also observe the person who has been brought to them for treatment to understand certain things for themselves. They indicated that they observe things like how the person behaves, how they speak, how they look or stare at things, how they are dressed, how they sit, whether they stay calm or jittery etc.

The observation

"One of the easiest ways of diagnosing the person is by looking at the person. I believe in using machines but I respect myself more than the machine because how did we manufacture a machine that looks into the mind of people? The machine is just a photocopy of the human mind. When I look at you, the spirit is able to tell me what caused your illness" (Male, Herbalist, 15 years of practice).

“Some are already acting irrationally when they are brought here. That informs me their mental state. Others are calm but through communication, you realize that the person isn’t mentally stable” (Male, Pastor 6 years of practice).

Bodily examination

Some of the practitioners indicated that they also engage in bodily examination of the patient to also get an idea of what might be wrong with him. This theme mainly came from the herbalists who believe that sometimes there is the need to examine the patients’ bodily parts to have an idea of the kind of herbs that might work well with them.

“I also do examine the eyes, ears. That is the reason why I claim it is a gift from God” (Male, Herbalist, 20 years of practice).

“Another way is talking the person to the hospital sometimes for various tests and examinations so that the cause would be now we know the cause. This is the last thing I do” (Male, Herbalist, 15 years of practice).

Seeking Spiritual Insight

The practitioners also indicated that the last diagnostic activity they engage in is seeking spiritual insight from a higher spiritual power. This theme mainly came from the practitioners whose practice have spiritual basis. They included the neo-prophetic pastors, traditional priests, the “mallams” and one herbalist, totalling 16 lay practitioners. They said that after gathering all information from observation and family members, they consult the source of their spiritual powers for a final decision and insight before they proceed with any other thing. The spiritual consultation gives insight into what the problem is and more important how it came about and how it can be remedied. Some participants said:

“Yes, sometimes it is beyond conservation because if the person has reached the point of going mad, the person would not be able to tell you anything sensible. We sit the person down and start to read the Quran to the person and if the person is possessed by a Jinn, they will show” (Male, Mallam, 11 years of practice).

“When they bring the sick person and I consult the gods, we call for a meeting. At that time, I would be under the influence of the spirits so the linguist is being told as to what illness it is and the kind of herbs needed to treat such an illness so the linguist go to the forest and get them. Then I would apply it on the sick person” (Male traditional priest, 18 years of practice).

“I do draw some inspirations from God as in receiving information by means of revelation from God.” (Male pastor, 28 years of practice).

Treatment Practices

After exploring their diagnostic practices, the study also examined treatment practices for schizophrenia among the non-professional mental health practitioners. The main themes that emerged from the practitioners’ treatment practices included spiritual healing, application of herbs and concoction, pacifications and forgiveness of sins.

Spiritual Healing

The dominant theme from the participants’ treatment practices was that of spiritual treatment. Most of the practitioners indicated that the cases of schizophrenia they get to handle are spiritual in nature and therefore they do a lot of spiritual healing. This theme mainly came from the practitioners whose practice have spiritual basis. They comprised the neo-prophetic pastors,

traditional priests and priestesses and the mallams. 16 of these non-professionals shared this theme.

There were however nuances in the means of spiritual healing, depending on the religious beliefs of the practitioners. However, putting them together, the dominant means of the spiritual healing were offering prayers, fasting, sacrificing to pacify gods, sacrificing to pacify aggrieved souls etc.

“They are all possessed. I have two main possessions; there is the mass possession and the lams. The lams is where the spirit would not stay in the body but touch part of the body and paralyse that part. There would be a defect in that part of the body, it may be your eye, mouth or your tongue and you cannot talk but in the case of mass, the jinn would be in the body trying to manipulate or use you the way it wants to use you. In the case of lams, we need to talk to the jinn and order it to take whatever it has put in the body out and within the twinkle of an eye, the hand that is paralyzed would start to work. If the jinn is in the body, we talk to the jinn, reach an agreement and then it goes. If it would not go, we have a way of punishing them. We have the xxx (09:00) that burns them, we have the xxx (09:02) that kills them” (Male, Mallam 11 years of practice).

“Right after enquiring from the person and his family members, I will further consult spiritually as to the authenticity of the information received and also any further way to approach it.... with this we will enquire from God as to the appropriate way to treat such a person” (Male, Mallam, 28 years of practice).

It’s mainly through fasting and prayers that I perform my work. Like how Jesus instructed his disciples that this kind can only be solved through prayer and fasting

after his disciples encountered a similar problem, so it tells us that there this form of predicament can only be solved through prayer and fasting. So the patient and I will fast (Male, Pastor, 28 years of practice).

Application of Herbs and Concoction

Another treatment method that emerged from the participants was the use of herbs. This theme mainly came from practitioners such as herbalists, traditional priest and some “mallams”. There was a total number of 15 non-professionals who shared this theme. They indicated that the herbs are mainly prepared in the form of concoction where the patient would take with some prescribed directives that should not be violated. Apart from the concoction, the herbs are sometimes also made into a pomade form where family members would smear on the body of the patient.

“What helps me treat my patients is the herbs I use. Some talk a lot and after taking the herbs, the person becomes quiet and that informs me that medicine is working” (Male, Herbalist, 15 years of practice).

“The gods will educate me in my dream as to which herbs to combine and apply. There are herbs the person would smear on the body and those that the person would have to bath with” (Male, traditional priest, 15 years of practice)

Pacification and Forgiveness of Sin

Another treatment practice that emerged from the practitioners’ narratives was that of pacification and forgiveness of sins. This theme came mainly from the neo-prophetic pastors, traditional priest and some “mallams”. They indicated that for the kind of schizophrenia that

originate from a curse based on something wrong the patient has done, the main way of treating it is to pacify the aggrieved part and for the person to confess and ask for forgiveness.

“So when the prayer of forgiveness of sins is not prayed, it becomes very difficult for that person to actually recover fully. So when one comes to our end we take the person through series of cleansing from sins through the art of prayer of forgiveness of sins. This helps in the rapid recovery of the person. Some are quite open and sincere about their sinful lives while others are not” (Male, Pastor 28 years of practice).

The foundation of Christianity is the word of God. Before one can receive divine healing, you have to take the person through the word of God. When you read psalm 107:20, it says that God sent forth His word to heal our diseases. Therefore, no matter how the person is, once you take the person through the word of God, and the person confesses his sin and accepts the word then you can add prayers. (Male, pastor, 8 years of practice).

“At times the gods will reveal that the person has wronged someone, for instance sleeping with someone’s wife. In cases where the family members know the one behind the curse, they are made to approach the person and ask for forgiveness on behalf of the sick. When it happens like that sacrifices has to then be made to appease the soul of the person who has been wronged.” (Male, traditional priest, 15 years of practice).

Research Question 2:

What are the views and perspectives of professional and non-professional mental health practitioners on collaborative schizophrenic care in Ghana?

This research questions examined the views and perspectives of both professional and non-professional mental health practitioners concerning collaborative mental health care within the context of schizophrenic care in Ghana. Findings from the study showed very nuanced and complex tensions between the practitioners concerning their readiness to collaborate for the purposes of schizophrenic care.

The findings show a clear divide between professional mental health practitioners and the non-professional practitioners on their willingness to collaborate. The professional mental health practitioners are more willing to collaborate with the non-professionals while the non-professionals are unwilling to collaborate. Different reasons account for the differences in the willingness of the two groups of practitioners.

4.3.2 Willingness of Professional Mental Health Practitioners to Collaborate

The professional mental health practitioners are more willing to collaborate with the non-professionals for various reasons which cohered around opportunity to streamline activities of non-professional practitioners, opportunity to annex the non-professional practice space and opportunity to impart mental health knowledge to the non-professionals. Each of these themes are explained below:

Streamlining Activities of Non-Professional Practitioners

The professional practitioners indicated their willingness to collaborate for schizophrenic care based on the fact that it can offer the possibility of streamlining the activities of the non-

professional practitioners. They indicated that the non-professional space is very abusive to patients and their caregivers and therefore such collaboration would ensure that the right treatment of patients and their relatives can be enforced. All the 10 professional mental health practitioners shared this theme. These are sample quotes from them:

“Some of the people have their own pastors and spiritual leaders and can’t say they should all come here. So I think the referral one, we make sure where they are going is the appropriate place and the practice there is the appropriate one and check on them”
(Female, Psychiatric Nurse, 9years of practice)

“There are nurses at the place where the patient is going. So if maybe it’s Kasoa we make the nurses there aware so that when they are going for home visit they can also pass through the church or” (Female, Psychiatric Nurse, 9years of practice)

Annexing the Non-Professional Practice Space

The narratives from the professionals also indicated their willingness to collaborate based on the fact that such a situation can help to make the non-professional space a place for first aid before being referred to the hospital for adequate treatment. Thus, they indicate that there would be a unidirectional referral where patients would be referred from the non-professional practice space to the professionals and not the other way round. They also outlined that such places are needful because they house a large number of the patients. There was a total number of 6 professionals who made mention of this.

“I think the second one is fine where Ghana Health Service control all these things because bringing them here to me I think there is going to be some bit of some rift. I mean a doctor is into dealing with a case and then...under rare circumstance will a

doctor refer a case to traditional leader or a herbalist” (male, psychiatric nurse 5 years of practice)

“Right now the only thing will be mental health inspection. The problem we have is that the mental health authority hasn’t gotten facilities so if we are to release all those who are in the prayer grounds and other places to come to the hospitals we can’t contain them so we are acknowledging the fact that they are housing a good number of people for now so it will be needful for us to do some work at their premises” (Male psychiatrist, 7 years of practice).

“Yes but not in that direction, a doctor can receive referrals from the lay but a doctor cannot refer to them” (Female’ psychiatrist 3 years of practice).

Imparting Knowledge of Schizophrenia to the Non-Professionals

The professional practitioners also indicated that a collaborative schizophrenic care would help them to impart knowledge of schizophrenia to the non-professionals to help them improve on their practice. This was outlined by all the 10 professionals.

“But I believe it was Ghana health Service who trained some traditional birth attendants teaching them on how to sterilize things and best practice within their scope. It went very well and we could use similar approach in this case. Both sides are educated to listen to the other person and what they have to offer. Further steps are taken to train this para-professional what they even need to look out for; to know that this is outside my scope” (Female, clinical psychologist, 6 years of practice).

“I think it should begin at the facility level and our role is to do more education. Let them know what is permissible... they are not aware of the mental health law and they

don't know what is in it. We need to educate them on it... the mental health law also recognises them and that is fine so we need to educate them on what they can and cannot do” (Male clinical psychologist, 6 years of practice).

“Yes there should be laid down clear rules. What we can do is to set up workshops with them and teach them from A to B” (Male, psychiatrist, 3 years of practice).

“It is something we are all into because they are the closest to the clients in the community and is a good thing, the only aspect is how they handle the patient, they must go through education to know how to handle them, that would be the best” (Female, psychiatric Nurse, 10 years of practice).

Unwillingness of the Non-professional Practitioners to Collaborate

The study found certain factors that might render collaborative schizophrenic care in Ghana very difficult to achieve from the perspective of the non-professional practitioners. These factors cohered around seven major themes; different diagnostic and treatment practices, perceived loss of autonomy, perceived arrogance of professional mental health practitioners, perceive lack of willingness of doctors to cross-referral, perceptions of taxing income, bureaucratic nature of orthodox practices.

Differences in Diagnostic and Treatment Practices

The non-professionals indicated that the differences in the diagnosis and treatment practices among different practitioners would make it very difficult to achieve. This was said by 14 of them. For example, some of them said:

“That is what I was telling you that the traditional priests use herbs but I don’t use herbs, is Gods intervention that help me heal the sick... and doctor too gives drugs I don’t give... just prayer I use to heal.... or am lying..., so coming together is impossible” (Male, pastor,30 years of practice).

“What we do and what the doctors do are completely different. If someone is sick and the person is brought here, there are herbs that we give to the person to take so I don’t think we can work with doctors.” (Male, Traditional priest, 9 years of practice).

“We the traditional priest have our herbs, the pastors have theirs and the doctors have theirs but we can’t downgrade the other. Most of the pastors condemn the work we do. I have not seen a traditional priest or a herbalist condemning a pastor but the pastors are always condemning those who use the traditional means. I know the folder water they apply on their members is from herbs. This can really make it hard to work with them.” (Male, traditional priest, 19 years of practice).

Perceived Loss of autonomy

The non-professionals also believe that collaborative schizophrenic care would be difficult because it would make them lose their autonomy and become subordinates to the professional practitioners. This came from 12 lay practitioners. Some of them said for instance that:

“But what really baffles my mind has to do with us being housed together with the orthodox practitioner in same facility. Meaning a practitioner might end up under the authority of someone else. For it is Allah who grants knowledge with which we work with and we are rather supposed to be under his authority. So I wouldn’t really approve of us coming together in a common place” (Male, Mallam, 20 years of practice).

“No!!!...I will not go in for any form of collaboration. I am a twin and God has given me the gift to heal the mentally ill...I came with this gift from my mother’s womb so I cannot be under anybody. It is a gift from God so I can’t be under anyone” (Female, herbalist, 38 years of practice).

Differences in faith

Another difficulty the non-professionals identified was the fact that there are fundamental faith differences which dictates what they do. These differences in faith do not provide opportunity for them to collaborate. 14 non-professionals expressed this. Below are some of the quotes from them.

“If someone sees a pastor going to see a traditional priest, they would say the pastor works with the power of the traditional priest. The pastors are always condemning us so we can’t collaborate with the pastors” (Male, traditional priest, 7 years of practice).

“I don’t have any problem with that but I am a Christian and I don’t really flow (...) I don’t go for “mallams” fetish priests because I know they end up getting other things” (Female, psychiatrist, 3years of practice).

“It wouldn’t be of help to us because our practices may differ. For instance, in times of our fasting there may be we need to have prayers for the entire patients. This may not go well with the practices of the other practitioners. Since I do strongly hold on to the faith of fasting and prayers, I do adhere to that practice a lot. As I was saying initially, we would also sometimes go through series of prayer of forgiveness. So with the government I, would have liked for the patients to be kept here especially when it has to with spiritual related matters” (Male, pastor, 28 years of practice).

Bureaucratic nature of orthodox practices

The non-professionals further indicated that the professional mental health practice space is too full of bureaucratic processes. Because they are not conversant with such bureaucracies, collaboration would be very difficult. 5 practitioners pointed out this.

“Another hindrance can be the bureaucratic nature of paper work and other stuffs... yes. You see these papers that I am holding, when we were trying to form an association, the paper work involved was inconvenient and made many “mallams” to leave Techiman to elsewhere. Unless those that were part of the association in Sunyani with whom further consultations were made with to come together and solidify the tenet of the association” (Male, Mallam, 20 years of practice).

“I mean bureaucracy, I mean the government system where this person has to sign this before this person can be taken to this and all this. I mean bureaucracy is health tight too. For there are not available, it will create problems” (Male psychiatric nurse, 5years of practice).

“I don't think this thing on the part of the government can make this collaboration work...let me tell you something, they will say bring this bring that, come and sign this today and the same thing tomorrow, go here and go there. My lady it will not be possible. Do you remember when they told us we were going to be issued an identification card? Where is it after the long queues wee joined, they should not come and spoil our job for us” (Male, herbalist, 17 years of practice).

Perceived Arrogance of Professional Practitioners

The non-professional practitioners indicated further that the professional practitioners behave arrogantly towards as if they (the professionals) know everything there is about ‘madness’. Because of this, they would find it difficult to collaborate with them. All the 20 non-professionals identifies this as a challenge and quotes from some of the professionals confirm this. Sample quotes are provided below:

“One of the challenges is accepting one another’s views and opinions especially those who have acquired their education to the highest level. I haven’t gone far in terms of education, I don’t even have a certificate in junior high level and I have realised that if you are have a discussion with one who thinks he is more learned than you, the person doesn’t really give you his attention. Even in the bible, there were people who weren’t learned but were given special grace to perform task” (Male, pastor, 8 years of practice).

“I would prefer the case where I can refer to the doctors when the need for their services arises though I know they will not refer theirs to mine” (Male, pastor, 28 years of practice).

“None of them because from my point of view, from where I am coming from, if the people knew as much as we do, they will obviously and immediately refer cases to us but they don’t have our knowledge. We have their knowledge, the spiritual aspect, we know about it and we have it but they don’t have the knowledge that we have”. (Male psychiatrist, 7 years of practice).

“Like I always say, they don’t have treatment for malaria but people with malaria are going to the church to pray instead of going to hospital, they go there and some will survive and others will die. So it’s like asking a doctor to refer someone with malaria to a traditionalist, this one I know some people have a problem with it and it’s because they don’t understand. So to me this collaboration is not possible, it will not happen in the first place so don’t have a choice in any of these you have mentioned (Male, psychiatrist, 7 years of practice).

Perceived Taxation of Income

The non-professional practitioners also indicated that any attempt to collaborate with those in the professional health settings would mean that their (the non-professionals) income would be tax by the government. They believe that such an instance would demand that they declare how much they charge for their service and tax paid on it. Something most of them indicated not being willing to do. For instance, some of them said:

We are also being tasked on the little earnings of ours. Suffice to say, we have not seen any benefit resulting from the payment of tax... what I can say is for those of us who are into this practise don’t benefit much from it because of the tax element and the paper work that are been involved (Male, mallam 20 years of practice).

“Hmmm...when these patients are brought here, some of them their relatives don’t come back again so their feeding and everything become our burden. It is going to be a double load on us should we be taxed on the little income we earn. You see the gentleman there washing? He has been here for the past six years and no family

member has ever visited, he is well now and even schooling at the senior high, I am taking him, so you see?” (Male herbalist, 12 years of practice).

Table 4.13: Summary of key qualitative findings (N=30)

LAY PRACTITIONERS REPRESENTATIONS OF SCHIZOPHRENIA	
Themes	Findings
The use of symptoms	<ul style="list-style-type: none"> • Transformed behaviour • Transformed speech
Loss of Awareness of State of Being	<ul style="list-style-type: none"> • Lack of insight into their illness
Categories of Schizophrenia	<ul style="list-style-type: none"> • Schizophrenia originating from family tensions • Schizophrenia originating from family genetics • Schizophrenia originating from a Curse
Diagnosis	<ul style="list-style-type: none"> • information from family • Seeking information from family and the patient • Observation • Bodily examination • Seeking spiritual insight
Treatment practices	<ul style="list-style-type: none"> • Spiritual healing • Application of herbs and concoction • Forgiveness of sins and pacifications
VIEWS AND OPINIONS ON COLLABORATION OF SCHIZOPHRENIC CARE	
Themes	Findings
Willingness of Professional Mental Health Practitioners to Collaborate	<ul style="list-style-type: none"> • Streamlining activities of non-Professional practitioners

	<ul style="list-style-type: none"> • Annexing the non-professional Practice Space • Imparting Knowledge of Schizophrenia to the Non-Professionals
Unwillingness of the Non-professional Practitioners to Collaborate	<ul style="list-style-type: none"> • Differences in Diagnostic and Treatment Practices • Perceived Loss of autonomy • Differences in faith • Bureaucratic nature of orthodox practices • Perceived Arrogance of Professional Practitioners • Perceived Taxation of Income

4.3.3 Brief Interpretations of Qualitative Findings

Findings from study 2 have shown that the non-professional mental health practitioners hold very simple representations of a complex condition as schizophrenia. Their understanding of the condition is marked by mainly the use of symptomatology. The practitioners mainly understand schizophrenia by using the symptoms that their patients they have diagnosed with schizophrenia exhibit. The symptoms they use to understand the conditions are transformed speech, transformed behaviour and lack of awareness of their state of being. Thus, the lay practitioners only depend on the outward manifestations or behaviours of schizophrenics to understand the condition.

The findings show further that there is a clear divide between professional mental health practitioners and the non-professional practitioners on their willingness to collaborate. The professional mental health practitioners are more willing to collaborate with the non-

professionals while the non-professionals are unwilling to collaborate. This means that the orthodox mental health practitioner welcomes the idea of collaborating with the lay practitioners in treating schizophrenia but the lay practitioners are reluctant towards collaborative schizophrenic care.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

Schizophrenia is argued to be one of the most challenging mental disorders in sub-Saharan African context (Monteiro, 2015). Majority of patients with schizophrenia do not receive the needed mental health care and attention within the professional mental health care system for various reasons (Becker & Kleinman, 2013; Collins et al., 2011). The reason is mostly attributed to the issue of accessibility and affordability schizophrenia. Because professional mental health care is limited, majority of patients with either do not have access to mental health facilities, cannot afford the service or both (Collins et al., 2011; Patel et al., 2007). This has created a situation where majority of families in sub-Saharan Africa seek treatment from lay or non-professional mental health practitioners (e.g. traditional priests, herbalists etc.) who are more accessible. In Ghana for instance, this treatment gap is found to be widening due to the increasing deplorable state of mental health system.

In the last decade, there have been increased calls for collaboration between orthodox and lay medical practice to ensure optimum health delivery in resource-poor contexts (Bombardieri & Easthope, 2000). In Africa, this call for collaboration has been emphasised heavily within the context of mental health delivery (Hanlon, Wondimagegn, & Alem, 2010). This requires a well-structured approach to developing a collaborative framework that would be accepted by all stakeholders in the mental health delivery. Several studies have been conducted to this effect to examine the dynamics of collaborative care between professional and non-professional

mental health practitioners in Africa. However, none of these studies have examined the dynamics of collaborative care within the context of schizophrenic care and treatment.

Using schizophrenic care and treatment in Ghana as a case study, this thesis sought to fill this gap by examining practitioners' views and opinions on the different systems of collaborations and also examined the dynamics of cross-referral within the context of schizophrenic care. A mixed-method approach was used to gather the data involving in-depth interviews of 30 practitioners and survey involving 110 practitioners. Among other objectives, the study first explored representations of schizophrenia among the non-professional practitioners. The study examined perspectives of the practitioners on the collaborative schizophrenic care. The study further examined stigma the practitioners face in their treatment of schizophrenia, as well as readiness to collaborate and attitudes the non-professionals hold about patients with schizophrenia.

This chapter provides detailed and in-depth discussions of the findings and their implications for mental health care in general and schizophrenic care in particular in Ghana. For the purposes of clarity, the findings from the qualitative and the quantitative components are discussed separately with the quantitative findings being discussed first followed by qualitative findings. After that, the findings from the two components of the study are integrated and discussed. The practical, research and/or theoretical implications of the findings in the current study are discussed. The chapter also presents some limitations of the current study and recommendations made for future research.

5.2 Discussion of Quantitative Findings

This section discusses the findings from the quantitative part of the study. Findings with regards to their attitudes towards collaborative schizophrenic care are discussed first, followed by findings on the stigma associated with schizophrenic care and then findings on attitudes towards patients with schizophrenia.

5.2.1 Attitudes towards Collaborative Schizophrenic Care

This objective examined attitudes the practitioners hold about collaborative care, measured as the willingness to recognize competence of other practitioners and willingness to have open communication with them. Findings from the study showed that the professional practitioners have more positive attitudes towards collaborative schizophrenic care than the non-professional attitudes. Compared to the non-professionals, the orthodox practitioners are more willing to recognize the competence of the non-professional practitioners and also more willing to let information flow between them. This finding is consistent with what was realized from the qualitative part of the study.

Several reasons could account for why the orthodox mental health practitioners are more willing to collaborate for schizophrenic care than the lay practitioners. Firstly, professional mental health practitioners recognise that majority of the mentally ill patients resort to non-professional practitioners as their first line of treatment. The professionals believe this leads to deterioration in the patient's condition so a collaborative care between them will offer the opportunity to streamline and regularise the activities of non-professionals in order to provide efficient care for patients. This is consistent with the qualitative findings.

Another reason why the professionals are in favour of collaboration is that they recognise there are limited facilities and personnel to cater for later larger number who need mental health

services in Ghana. For this reason, the facilities of the non-professionals could serve as a complement to house the mentally ill. In that regard basic training on the nature of the illness and how to handle the patients would be given to the healers through regular workshops while the professional mental health practitioners make regular visits to such facilities to give them medications.

Also the orthodox practitioners believe that when there is collaboration, the activities of the non-professional mental health practitioners would be put under scrutiny therefore the abuses that have been recorded among the non-professional mental health practitioners in their dealing with patients could be put in check. By so doing abuses such as chaining, leaving patients to the mercies of the sun and rain, letting the sick person fast etc. could be prevented.

5.2.2 Stigma Associated with Schizophrenic Care

This objective examined the level of stigma experienced by the practitioners as a result of their treatment of schizophrenia. The findings from the study showed that the professional mental health practitioners experience higher levels of stigma associated with schizophrenic care than non-professional mental health practitioners. The professional mental health practitioners experience higher discrimination and lower positive aspect of stigma compared to their non-professional counterparts.

These findings are contradictory to what some previous studies have reported. Several studies (e.g Kelly, Perkins, Fuller, & Parker, 2011; Pinto, Wall, Yu, Penido, & Schmidt, 2012) showed that orthodox medical professionals suffer less stigma compared to other non-professional health practitioners. The current study however shows the reverse is the case among professional mental health practitioners in Ghana. With interactions with the practitioners during the interviews, several issues came up that could account for why the professionals feel

more stigmatized than the non-professionals. First of all, some of the professional mental health practitioners, specifically psychiatrists reported of derogatory attitudes and comments even right from medical school from colleague doctors. Some explained that they were at times ridiculed with words like “psychiatrists are not real doctors”, you are too brilliant to specialise in psychiatry, “psychiatrists are crazy themselves” etc. According to them some physicians put up some attitudes that denigrate them when they meet.

Furthermore, inequalities in distribution of resources by their employers was seen as a contributing factor to this finding. Some complained that less funding is allocated to mental health unlike other specialties. According to some of them much is not invested in conducting researches that could enhance the quality of care of the mentally ill because it doesn't kill speedily like conditions such as malaria. In view of this attention is mostly shifted from the field of psychiatry to others that employers think urgent attention is needed. An example was cited by one psychiatrist that “if currently we need money and then those at the maternity unit also come that they need money, the obvious truth is that the money will be allocated to them instead”. In terms of their allowances too they feel they are discriminated against at times because they are mental health practitioners.

5.2.3 Attitudes towards Patients with Schizophrenia

This objective assessed the attitudes that the lay practitioners hold about patients with schizophrenia. The findings showed significant mean differences in only one aspects of attitudes towards patients with schizophrenia; supportive attitude. The pastors had more positive or supportive attitudes towards patients with schizophrenia, compared to other non-professional mental health practitioners.

These significant differences could be explained by differences in educational levels of the lay practitioners. It was observed from the background characteristics that among four non-professional groups, the pastors had the highest level of education. Therefore, it could be that they are more enlightened on schizophrenia than the others. It could be that they have read about it themselves and have adopted a more positive stance with regards to the condition than the others.

One other explanation to this finding is their belief in God as the Omnipotent. To them no illness is greater than God. Therefore, they are optimistic about any form of mental illness that is brought to them. Knowing that there is someone all powerful operating in them and working his miracles through them, every illness including schizophrenia can be healed when there is faith. To them nothing but faith determines as to whether one would be healed or not therefore they are positive about the mentally ill and their recovery.

5.3 Discussion of Qualitative Findings

The qualitative component of the study explored two key objectives; (i) explored the representations of schizophrenia among the lay or the non-professional mental health practitioners and (ii) explored perspectives of both professional and non-professional mental health practitioners on collaborative schizophrenic care in Ghana. The discussion of the qualitative findings is therefore organized around these two thematic areas: representations of schizophrenia among non-professional mental health practitioners in Ghana and perspectives of mental health practitioners in Ghana on collaborative schizophrenic care.

5.3.1 Representations of Schizophrenia among Non-Professional Mental Health

Practitioners in Ghana

This sub-section of the qualitative study explored how lay mental health practitioners make sense of schizophrenia and how their representations shape their diagnostic and treatment practices. Majority of studies (e.g. Lin et al., 2016; Wood et al., 2014) that have examined perceptions of schizophrenia have done so among the general public and the findings largely showed predominant stigmatizing attitudes towards patients with schizophrenia (Lin et al., 2016; Wood et al., 2014).

Studies exploring how lay mental health practitioners make sense of schizophrenia in resource-poor African context are very limited. However, within the context of collaborative schizophrenic care, it is very important for the practices of lay mental health practitioners about schizophrenia to be understood to enhance how to reach them within their practice space. This can only be done when there is in-depth understanding of how lay practitioners make sense of schizophrenia and how they diagnose and treat the condition.

This section conducted in-depth exploration of representations of schizophrenia among the lay mental health practitioners. Findings from the study showed that representations of schizophrenia among the lay practitioners cohere around their understanding of the condition, their explanatory models of categories of the condition, their diagnostic practices and their treatment practices.

How they make sense of schizophrenia

Concerning how the lay practitioners make sense of schizophrenia, the findings showed that their understanding of the condition is marked by mainly the use of patterns of symptoms. The

practitioners mainly understand schizophrenia by using the symptoms that their patients they have diagnosed with schizophrenia exhibit. The symptoms they use to understand the conditions are transformed speech, transformed behaviour and lack of awareness of their state of being.

This means that the lay practitioners only depend on the outward manifestations or behaviours of schizophrenics to understand the condition. Schizophrenia is argued to be a very complex long term mental health disorder involving disorientations in relation to thought, emotions and behaviours that is characterized by inappropriate actions and emotions, withdrawal from reality and personal relationships, faulty perceptions, delusions and hallucinations, and a sense of mental fragmentations (Carr & McNulty, 2016; Choudhury & Slaby, 2016).

This shows that schizophrenia is affected by complex internal cognitive and neurological processes that only manifest in behaviours and actions (Choudhury & Slaby, 2016). However, the understandings of the lay mental health practitioners have only a surface idea of what the condition is. The symptomological underpinning of their understanding of schizophrenia means that the lay practitioners only depend on the outward manifestations to understand a condition which is argued to be one of the most complex of all mental disorders (Kendler, 2017).

Some of the symptoms the practitioners mentioned nonetheless coincide with some clinically and empirically proven symptoms of the condition. For instance, they mentioned of transformed behaviour and lack of awareness of their state of being which coincide the clinically and empirically proven disorientations of thoughts, emotions and behaviours as well as delusions and hallucinations. This means that the lay mental health practitioners do not use internal cognitive mechanism to understand the condition.

Categorizations of Schizophrenia

The most recent Diagnostic and Statistical Manual of mental disorders (DSM 5) has done away with categorization of schizophrenia into sub-types. The rationale for doing so is that the subtypes (i.e. disorganized, paranoid, catatonic and undifferentiated) are unstable conditions which have been of little clinical importance and scientifically valid and reliable (Kendler, 2017). However, findings from the study showed that categorization of schizophrenia are still strongly held among the lay practitioners. They basically used their explanatory models of perceived causes of schizophrenia to categorize the condition to three major categories; those that are as a result of family tensions, those that are as a result of a curse and those that are as a result of genetic.

Categorizations have been found to be very fundamental to lay knowledge of mental health (Rogers & Pilgrim, 2014), especially among non-western or low income countries (Furnham & Hamid, 2014). Categorizations are found to help individuals who lack sophisticated knowledge to make sense of complex phenomenon by breaking them down into comprehensible units. Within the context of mental illness, public perceptions of certain disorders, including schizophrenia are affected by one form of categorization or another (Furnham & Hamid, 2014).

This explains why categorizations still persist with schizophrenia among the lay practitioners in Ghana. They mainly use explanatory models that emphasises spiritual basis to classify two groups of schizophrenia; those arising from family tensions and those arising from curses from outside the family space. This in line with other studies that have reported that spirituality constitutes a dominant explanatory model of mental illness among lay practitioners. For instance, similar findings have also been observed among Pentecostal clergy in Ghana

concerning mental illness. Asamoah et al (2014) reported among 20 male Pentecostal clergy that they lean more towards a diabolical explanatory model of mental health that emphasises on spiritual malice than a biomedical model.

Diagnostic and Treatment Practices for Schizophrenia among the Lay Practitioners

Findings from the study showed that the complex sets of practices are used in diagnosing whether an individual has schizophrenia or not. The main diagnostic practices identified were seeking information from family members, gathering information through observation, seeking further knowledge using bodily examination and finally seeking spiritual insight. There were some notable patterns in their diagnostic practices. All the practitioners used seeking information from family members, gathering information through observations. The herbalists combined these two practices with body examinations while the pastors, traditional priests and “mallams” combined the two practices with seeking spiritual insights.

With regards to their treatment practices, the findings from the study showed that the lay mental health practitioners used three main practices in treating schizophrenia. They included spiritual healing, application of herbs and concoction, pacifications and forgiveness of sins. Their treatment practices were shaped by their explanatory models of schizophrenia. Spiritual-related treatment underpinned much of their treatment practices with the idea that because schizophrenia is spiritually cause, when the spiritual is taken care of, the outward manifestations would disappear with time.

These findings are consistent with what has been reported by other studies on other chronic mental health disorders (Furnham & Hamid, 2014; Lin et al., 2016; Osafo et al., 2015; Wood et al., 2016). For instance, Osafo et al., (2015) has reported among neo-prophetic ministers in

Ghana on mental health delivery they viewed mental illness as a spiritual problem rather than a biomedical one. They therefore use two main approaches in their treatment of mental illness; hope induction approach and prophetic deliverance approach to treat psychopathologies.

Integrating the findings on the representations of schizophrenia, the current study shows that lay mental health practitioners hold socio-culturally grounded knowledge of schizophrenia. Read, Doku and de-Graft Aikins, (2014) for instance argue that in Ghana, schizophrenia is a heavily contested mental disorder within the socio-cultural space that individuals draw from spiritual and cultural to make sense of. These knowledge systems are generally drawn from spiritual or religious knowledge source and socio-cultural sources. Their explanatory models of schizophrenia are found to shape their diagnostic and treatment practices.

5.3.2 Perspectives on Collaborative Care

The second objective of the qualitative component of the study explored perspectives of both professional and non-professional practitioners on the idea of collaborative care. The relationship between these two different systems of health practitioners has always bothered on tension in relations to different ideologies concerning health and illness which happen to cause friction between them. However, some studies have reported that there are more areas of consensus between these different health systems which can enhance cooperation between them in the delivery of health.

The findings from the current study show a clear divide between professional mental health practitioners and the non-professional practitioners on their willingness to collaborate. The professional mental health practitioners are more willing to collaborate with the non-professionals while the non-professionals are unwilling to collaborate. This means that the orthodox mental health practitioner welcomes the idea of collaborating with the lay

practitioners in treating schizophrenia but the lay practitioners are reluctant towards collaborative schizophrenic care.

The findings in the current study contradict findings in earlier studies on collaborative health care in (e.g. Campbell-Hall et al., 2010; de-Graft Aikins, 2005). Campbell-Hall et al., (2010) for instance, have reported among traditional healers in mental health delivery that even though they are open to training in biomedical approaches to mental health treat, Western biomedical mental health practitioners are less interested in any collaborative arrangements. In the current study however, the biomedical mental health practitioners are found to be rather willing to collaborate while the non-professional practitioners are not willing to do so.

Other studies have however, showed within the context of ethnomedical treatment of diabetes a common ground where biomedical and traditional practitioners could collaborate to ensure holistic care. For instance, using diabetes care in Ghana as a case study, de-Graft Aikins, (2005) found among a group of biomedical practitioners (doctors and nurses) and ethnomedical (herbalists and priests) that there is a scope for collaboration because both groups share more consensual ideas about the diverse causes of diabetes which requires different system of treatment at the biological, psychological and the social levels.

In the current study however, the findings show little common grounds for agreement among the two groups of practitioners. The reasons for the findings in the current study could be that collaborative care inure to the benefit of the orthodox mental health practitioners and that the lay practitioners think they stand the chance to be disadvantaged by any attempt to collaborate. For instance, the professional mental health practitioners are more willing to collaborate with the non-professionals for various reasons as opportunity to streamline activities of non-

professional practitioners, opportunity to annex the non-professional practice space and opportunity to impart mental health knowledge to the non-professionals.

The non-professionals on the other hand found certain factors that might render collaborative schizophrenic care in Ghana very difficult to achieve from the perspective of the non-professional practitioners. These factors included; different diagnostic and treatment practices, perceived loss of autonomy, perceived arrogance of professional mental health practitioners, perceive lack of willingness of doctors to cross-referral, perceptions of taxing income, bureaucratic nature of orthodox practices.

These findings are consistent with those of other studies (e.g. Ag-Ngibise et al., 2010; Shields et al. 2016). Shields et al. (2016) for instance, examined origins, use and outcomes of a collaborative programme between faith-based and allopathic mental health practitioners in India. They reported that collaboration is extremely challenging and will require trust, rapport-building and extensive open dialogue. The faith-based practitioners were reported to perceive allopathic mental health practitioners of intrusion into their territory which they thought as posing a threat to their livelihood. The tension has mainly been found to be on the ideologies surrounding aetiology of illness. Similar findings have been reported in Ghana concerning the tension between traditional healers and biomedical practitioners. Ag-Ngibise et al. (2010) has also reported in Ghana that the relationship between the two systems of mental health delivery is characterised by lack of mutual respect, suspicion of traditional healers by biomedical practitioners and as such least likely to collaborate with each other.

The findings however contradict the other studies (e.g. Kayombo et al., 2014; Madiba, 2014) who have also studied similar populations. Madiba (2014) for instance has also reported similar

findings in the treatment of HIV/AIDS in Botswana. Madiba (2014) reported that the traditional healers had positive attitude towards biomedical health practitioners and referred to them as colleagues. As such, the traditional practitioners reported of being willing to share knowledge with, refer patients to and are eager to learn biomedical skills from their biomedical practitioners. Similar findings have been reported between traditional and biomedical healers in the treatment and management of HIV/AIDS in Tanzania. Kayombo et al., (2014) found among a group of traditional healers who (claim) to be involved in the treatment of HIV/AIDS, that they were willing to collaborate and open doors to other practitioners.

5.4 Limitations of the Study

There are some limitations that should guide interpretations and applications of the findings in the study. First of all, the current study explored the issues between professional and non-professional mental health practitioners on collaborative schizophrenic care. The findings are therefore limited to biomedical-lay practitioner relationship and do not translate into inter-lay practitioner relationships.

Another limitation worth noting is the fact that the qualitative aspect of this study is culturally-based. There is the issue of culture and its influence on psychopathology. The cultural differences in the three regions which participants were sampled from could influence their understanding of schizophrenia and subsequently their approaches to diagnosing and treating it.

The survey aspect of the study could not also control for other external or extraneous variable that could have influenced participants' perspective on collaborative schizophrenic care. Caution therefore advised in the interpretations and or applications of the findings.

The study is also limited in scope as it does not cover the entire regions in Ghana. Furthermore, the study is limited because it did not take into consideration the various denominations within the religious groups which could have given different variations in terms of representations of schizophrenia and also their views with regards to collaboration.

Finally, equal numbers of paraprofessional subgroups were not recruited for the study

5.5 Recommendations Based on the Study

The findings from the study have several implications, both for practice and research. The qualitative and the quantitative findings are integrated in discussing the recommendations of the study.

5.5.1 Practical Recommendations

Based on the findings from the study, several recommendations are made in order to improve collaborative schizophrenic care in Ghana.

First of all, putting the qualitative and the quantitative findings together, some nuances emerge from the two. First of all, both the qualitative and the quantitative findings show that the professional mental health practitioners are more willing to collaborate for schizophrenic care compared to the non-professional practitioners. However, there is a wide discrepancy in the perceptions of the non-professionals practitioners. For instance, from the qualitative findings the non-professionals mentioned that the professional practitioners look down upon their (the lay practitioners) practice. But the quantitative findings show that the professionals are more willing to respect the competence of the non-professional practitioners and are also more willing to let information flow between them. This perception among the lay practitioners, which appear to be empirically false, might be causing their hesitance to collaborate.

Based on this finding, it is recommended that the empirically unsubstantiated perceptions of non-professional practitioners about the professionals not recognising them should be dealt with directly. The researcher recommends that in order to erase such perception, professional mental health practitioners should go to the lay practitioners instead of inviting the lay practitioners to come.

Secondly, the qualitative findings also showed that differences in faith are fundamental to explanatory models, diagnoses and treatment practices of schizophrenia among the lay practitioners. Based on this it is recommended that attempts at ensuring collaborative schizophrenic care should give critical consideration to religious affiliations of the lay mental health practitioners.

Also, the quantitative findings showed again that the professional practitioners experience high levels of stigma than the non-professional practitioners. Experience from gathering the qualitative data showed that the stigma faced by the professional practitioners comes from other professional practitioners within the biomedical health systems such as medical doctors, nurses, institutional neglect etc. Based on this, it is recommended that stigma among professional mental health practitioners should be tackled at the structural level by exposing the institutional factors that fuel this stigma among the professional practitioners.

5.5.2 Recommendations for Future Research

The current study has made substantial contribution to the collaborative care dialogue within the mental health context. It is therefore important that other studies build on this study for deeper understanding. The following recommendations are therefore made for future studies:

1. Future studies should consider examining the dynamics of collaborative relationships among the different groups of non-professional mental health practitioners themselves. The current study has shown that differences in faith are fundamental to explanatory models of schizophrenia. It is therefore imperative to understand the possibility of collaboration among lay practitioners with different faith and religious systems.
2. Future studies should also concentrate on areas of Ghana where mental health facilities are virtually non-existent to examine the perspectives of the lay mental health practitioners there.
3. For the sake of generalizability, a country-wide level of study is also encouraged

5.6 Conclusion

The movement for collaborative mental health care in resource-poor contexts has gained popularity in Africa. In Ghana for instance, with the gradual attention being paid to mental health (with the establishment of Mental Health Authority), there is the need for evidence-based research that inform policy and practice surrounding collaborative mental health care. Using schizophrenic care and treatment in Ghana as a case study, this thesis examined practitioners' views and opinions on the different systems of collaborations within the context of schizophrenic care.

A mixed-method approach was used to gather the data involving in-depth interviews of 30 practitioners and survey involving 110 practitioners. Among other objectives, the study first explored representations of schizophrenia among the non-professional practitioners. The study examined perspectives of the practitioners on the collaborative schizophrenic care. The study further examined stigma the practitioners face in their treatment of schizophrenia, as well as

readiness to collaborate and attitudes the non-professionals hold about patients with schizophrenia.

Findings from the qualitative part showed that representations of schizophrenia among the non-professional practitioners were marked by mainly using symptomatology (transformed speech, transformed behaviour and lack of awareness of their state of being). They categorize schizophrenia based on their explanatory models of schizophrenia (that are as a result of family tensions, those that are as a result of a curse and those that are as a result of genetic). Complex set of practices (information from family, observation, bodily examination and seeking spiritual insight) are used in diagnosing whether an individual has schizophrenia. Treatment practices mainly included: spiritual healing, application of herbs and concoction, pacifications and forgiveness of sins

On Collaborative Care, the findings showed that the professional mental health practitioners are more willing to collaborate with the non-professionals while the non-professionals are unwilling to collaborate. The professional mental health practitioners are more willing to collaborate with the non-professionals for various reasons which cohered around opportunity to streamline activities of non-professional practitioners, opportunity to annex the non-professional practice space and opportunity to impart mental health knowledge to the non-professionals. The non-professionals were not willing to collaborate for reasons including; differences in diagnostic and treatment practices, perceived loss of autonomy, perceived arrogance of professional mental health practitioners, perceive lack of willingness of doctors to cross-referral, perceptions of taxing income, bureaucratic nature of orthodox practices.

Further, the quantitative component showed that professional practitioners have more positive attitudes towards collaborative schizophrenic care than the non-professional attitudes.

Professional mental health practitioners experience higher levels of stigma associated with schizophrenic care than non-professional mental health practitioners. The results show significant mean differences in only one aspects of attitudes towards patients with schizophrenia; supportive attitude. The pastors had more positive or supportive attitudes towards patients with schizophrenia, compared to other non-professional mental health practitioners.

In conclusion, the findings from the study shows that there are more complex issues to be dealt with for the purposes of ensuring collaborative schizophrenic care in Ghana. Among them are the empirically unsubstantiated perceptions of lay mental health professionals about the biomedical mental health practitioners and the institutional factors that cause stigma among professional mental health practitioners.

REFERENCES

- Ae-Ngibise, K., Cooper, S., Adiibokah, E., Akpalu, B., Lund, C., Doku, V., & Consortium, M. R. P. (2010). 'Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. *International Review of Psychiatry*, 22(6), 558-567.
- Aikins, A. d.-G. (2002). Exploring biomedical and ethnomedical representations of diabetes in Ghana and the scope for cross-professional collaboration: a social psychological approach to health policy. *Social Science Information*, 41(4), 625-652.
- Aikins, A. d.-G. (2005). Healer shopping in Africa: new evidence from rural-urban qualitative study of Ghanaian diabetes experiences. *Bmj*, 331(7519), 737.
- Aikins, A. d.-G., & Koram, K. (2017). Health and Healthcare in Ghana, 1957–2017. In E. Aryeetey & R. Kanbur (Eds.), *The Economy of Ghana Sixty Years After Independence* (pp.365). Oxford, U.K.: Oxford University Press.
- Asamoah, M. K., Osafo, J., & Agyapong, I. (2014). The role of Pentecostal clergy in mental health-care delivery in Ghana. *Mental Health, Religion & Culture*, 17(6), 601-614.
- Barimah, K. B., & Akotia, C. S. (2015). The Promotion of Traditional Medicine as Enactment of Community Psychology in Ghana. *Journal of Community Psychology*, 43(1), 99-106.
- Becker, A. E., & Kleinman, A. (2013). Mental health and the global agenda. *New England Journal of Medicine*, 369(1), 66-73.
- Bombardieri, D., & Easthope, G. (2000). Convergence between orthodox and alternative medicine: A theoretical elaboration and empirical test. *Health*, 4(4), 479-494.

- Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V., Flisher, A. J., & Consortium, M. R. P. (2010). Collaboration between traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services. *Transcultural psychiatry*, *47*(4), 610-628.
- Carr, A., & McNulty, M. (2016). *The handbook of adult clinical psychology: an evidence based practice approach*: Routledge.
- Cheever, L. W., Kresina, T. F., Cajina, A., & Lubran, R. (2011). A model federal collaborative to increase patient access to buprenorphine treatment in HIV primary care. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *56*, S3-S6.
- Choudhury, S., & Slaby, J. (2016). *Critical neuroscience: A handbook of the social and cultural contexts of neuroscience*: John Wiley & Sons.
- Coles, S., & Mannion, A. (2017). Critical Clinical Psychology *The Palgrave Handbook of Critical Social Psychology* (pp. 557-578): Springer.
- Collins, P. Y., Patel, V., Joestl, S. S., March, D., Insel, T. R., Daar, A. S., . . . Fairburn, C. (2011). Grand challenges in global mental health. *Nature*, *475*(7354), 27-30.
- de-Graft Aikins, A. (2015). Mental illness and destitution in Ghana: a social psychological perspective. *The Culture of Mental Illness and Psychiatric Practice in Africa*, 112-143.
- Freeman, M., & Motsei, M. (1992). Planning health care in South Africa—is there a role for traditional healers? *Social Science & Medicine*, *34*(11), 1183-1190.
- Furnham, A., & Hamid, A. (2014). Mental health literacy in non-western countries: a review of the recent literature. *Mental Health Review Journal*, *19*(2), 84-98.
- Gilbert, J. H., Yan, J., & Hoffman, S. J. (2010). A WHO report: framework for action on interprofessional education and collaborative practice. *Journal of Allied Health*, *39*(3), 196-197.

- González-Torres, M. A., Oraa, R., Arístegui, M., Fernández-Rivas, A., & Guimon, J. (2007). Stigma and discrimination towards people with schizophrenia and their family members. *Social psychiatry and psychiatric epidemiology*, 42(1), 14-23.
- Hanlon, C., Wondimagegn, D., & Alem, A. (2010). Lessons learned in developing community mental health care in Africa. *World Psychiatry*, 9(3), 185-189.
- Hansdak, S. G., & Paulraj, R. (2013). Are we doing harm by omission? Addressing religiosity of the mentally ill. *World Psychiatry*, 12(1), 40-40.
- Jacob, K. (2017). Mental health services in low-income and middle-income countries. *The Lancet Psychiatry*, 4(2), 87-89.
- Jeffries, V., Slaunwhite, A., & Wallace, N. (2000). *Collaborative care for mental health and substance use issues in primary health care: overview of reviews and narrative summaries*: Mental Health Commission of Canada.
- Kates, N., Mazowita, G., Lemire, F., Jayabarathan, A., Bland, R., Selby, P., . . . Audet, D. (2011). The evolution of collaborative mental health care in Canada: A shared vision for the future. *Canadian Journal of Psychiatry*, 56(5), 11.
- Kayombo, E. J., Uiso, F. C., Mbwambo, Z. H., Mahunnah, R. L., Moshi, M. J., & Mgonda, Y. H. (2007). Experience of initiating collaboration of traditional healers in managing HIV and AIDS in Tanzania. *Journal of Ethnobiology and Ethnomedicine*, 3(1), 6.
- Kelly, B. J., Perkins, D. A., Fuller, J. D., & Parker, S. M. (2011). Shared care in mental illness: A rapid review to inform implementation. *International journal of mental health systems*, 5(1), 31.
- Komiti, A., Judd, F., & Jackson, H. (2006). The influence of stigma and attitudes on seeking help from a GP for mental health problems. *Social psychiatry and psychiatric epidemiology*, 41(9), 738-745.

- Madiba, S. (2014). HIV/AIDS knowledge and practices of traditional health practitioners in Tutume sub-district: Implications for collaboration in HIV/AIDS care in Botswana. *PULA: Botswana Journal of African Studies*, 28(1).
- Magliano, L., Punzo, R., Strino, A., Acone, R., Affuso, G., & Read, J. (2016). General Practitioners' Beliefs About People With Schizophrenia and Whether They Should Be Subject to Discriminatory Treatment When in Medical Hospital: The Mediating Role of Dangerousness Perception.
- McKinlay, E. M., Morgan, S. J., Gray, B. V., Macdonald, L. M., & Pullon, S. R. (2017). Exploring interprofessional, interagency multimorbidity care: case study based observational research. *Journal of Comorbidity*, 7(1), 64-78.
- Monteiro, N. M. (2015). Addressing mental illness in Africa: Global health challenges and local opportunities. *Community Psychology in Global Perspective*, 1(2), 78-95.
- Morant, N. (2006). Social representations and professional knowledge: The representation of mental illness among mental health practitioners. *British journal of social psychology*, 45(4), 817-838.
- Ofori-Atta, A., Read, U., & Lund, C. (2010). A situation analysis of mental health services and legislation in Ghana: challenges for transformation. *African Journal of Psychiatry*, 13(2), 99-108.
- Osafo, J. (2016). Seeking paths for collaboration between religious leaders and mental health professionals in Ghana. *Pastoral Psychology*, 65(4), 493-508.
- Osafo, J., Agyapong, I., & Asamoah, M. K. (2015). Exploring the nature of treatment regimen for mentally ill persons by neo-prophetic ministers in Ghana. *International Journal of Culture and Mental Health*, 8(3), 325-339.

- Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., . . . van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet*, *370*(9591), 991-1005.
- Pinto, R. M., Wall, M., Yu, G., Penido, C., & Schmidt, C. (2012). Primary care and public health services integration in Brazil's unified health system. *American journal of public health*, *102*(11), e69-e76.
- Rhodes, P., & Conti, J. (2016). Why Clinical Psychologists Should Read Philosophy: An Introduction. *Australian Clinical Psychologist*, *2*(1).
- Shields, L., Chauhan, A., Bakre, R., Hamlai, M., Lynch, D., & Bunders, J. (2016). How can mental health and faith-based practitioners work together? A case study of collaborative mental health in Gujarat, India. *Transcultural psychiatry*, *53*(3), 368-391.
- Sidani, S., & Fox, M. (2014). Patient-centered care: clarification of its specific elements to facilitate interprofessional care. *Journal of interprofessional care*, *28*(2), 134-141.
- Strayer, C. S. (2013). Evaluating Biomedical and Ethnomedical Health Care Models in Ghana. *Journal of Africana Religions*, *1*(3), 384-390.
- Tuckett, A. G. (2005). Applying thematic analysis theory to practice: a researcher's experience. *Contemporary nurse*, *19*(1-2), 75-87.
- Van Boekel, L. C., Brouwers, E. P., Van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. *Drug and alcohol dependence*, *131*(1), 23-35.
- van Dongen, J. J. J., Lenzen, S. A., van Bokhoven, M. A., Daniëls, R., van der Weijden, T., & Beurskens, A. (2016). Interprofessional collaboration regarding patients' care plans in

primary care: a focus group study into influential factors. *BMC family practice*, 17(1), 58.

Warner, R. (2009). Recovery from schizophrenia and the recovery model. *Current opinion in psychiatry*, 22(4), 374-380.

APPENDICES

APPENDIX A

UNIVERSITY OF GHANA



Official Use only
Protocol number

Ethics Committee for Humanities (ECH)

PROTOCOL CONSENTFORM

Section A- BACKGROUND INFORMATION

Title of Study:	Exploring Cross Professional Collaborations among Professional and Lay Mental Health Practitioners: A Study of Schizophrenic Care in Ghana.
Principal Investigator:	Rita Nkrumah MPhil Psychology Student
Certified Protocol Number	

Section B- CONSENT TO PARTICIPATE IN RESEARCH

General Information about Research

The main aim of the study is to examine views and opinions about the different collaborative frameworks between professional and lay mental health practitioners using schizophrenia care in Ghana as a case study. The areas that would be assessed include understanding of schizophrenia among professional and lay mental health practitioners. After that, it will examine how their understanding influence their treatment practices. Their views, opinions and preferences on the different collaborative systems (cooperation, incorporation and total

integration) will be examined. It will also assess the dynamics of cross-referrals of schizophrenic cases between professional and mental health practitioners. The study will contribute to the efforts at building collaboration among the various mental health practitioners by providing insight into the framework that the various stakeholders are willing to work with in helping bridge the high mental health treatment gap in Ghana.

Participation will involve responding to individual in-depth interview and a self-report questionnaire which will last for 25 to 30 minutes.

Benefits/Risk of the study

The study does not involve any known risks except the time and effort spent during the interview or responding to the questionnaire. The study has no direct benefit for participants.

Confidentiality

Any and all information obtained from you during the study will be confidential. The In-depth interview will be taped-recorded with the permission from participant. Apart from the principal student investigator, other groups that may have direct access to the research records include principal and co-supervisors, research assistants at the point of doing transcription or data entry and if need be. All data collected will be used for academic purposes only and as such ethical principles of privacy and confidentiality will be ensured.

Compensation

Participants will be given airtime credits worth Five Ghana cedis (GH¢5) at the end of the interview to show appreciation for their time and efforts in participating in the study.

Withdrawal from Study

Your participation is entirely voluntary. You may refuse to participate in this research. Such refusal will not have any negative consequences for you. If you begin to participate in the research, you may at any time, for any reason, discontinue participation.

Contact for Additional Information

Should you have any concerns for further clarifications, you can contact the researcher on 0546211049 or through the mail at ritankrumah@yahoo.com. You can also write to the Department of Psychology, University of Ghana, Legon.

If you have any questions about your rights as a research participant in this study you may also contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at ech@isser.edu.gh / ech@ug.edu.gh or 00233- 303-933-866.

Section C-VOLUNTEER AGREEMENT

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

Name of Volunteer

Signature or mark of volunteer

Date

If volunteers cannot read the form themselves, a witness must sign here:

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

Name of witness

Signature of witness

Date

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

Name of Person who Obtained Consent

Signature of Person Who Obtained Consent

Date

APPENDIX B



UNIVERSITY OF GHANA

ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

P. O. Box LG 74, Legon, Accra, Ghana

10th October 2016

My Ref. No.....

Ms. Rita Nkrumah
Department of Psychology
University of Ghana
Legon

Dear Ms. Nkrumah,

ECH 021/15-16: EXPLORING CROSS PROFESSIONAL COLLABORATIONS AMONG PROFESSIONAL AND LAY MENTAL HEALTH PRACTITIONERS: A STUDY OF SCHIZOPHRENIC CARE IN GHANA

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below:

Expiry Date: 30/03/17
On Agenda for: Initial Submission
Date of Submission: 12/09/16
ECH Action: Approved
Reporting: Quarterly



Please accept my congratulations.

Yours Sincerely,

Rev. Prof. J. O. Y. Mante
ECH Chair

CC: Dr. Maxwell Asumeng, Department of Psychology

Tel: +233-303933866

Email: ech@ug.edu.gh | ech@isser.edu.gh

APPENDIX C



UNIVERSITY OF GHANA
DEPARTMENT OF PSYCHOLOGY
SCHOOL OF SOCIAL SCIENCES

PSYC 2/33/02
Ref. No.....

24th January, 2017

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION
MS. RITA NKRUMAH

The above-named is an M.Phil Clinical Psychology student at the University of Ghana, Legon.

In partial fulfillment of the requirement for the award of the M.Phil degree Ms. Rita Nkrumah has to write and submit an original thesis. She has selected the topic: "Exploring cross professional collaborations among professional and lay mental health practitioners: A study of schizophrenic care in Ghana."

To enable her collect data for her work she would need to administer questionnaires and/or conduct interviews. She has selected your institution as suitable for her data collection.

Attached is her institutional approval/clearance to enable her carry on with her research work.

Any assistance you may give her would be greatly appreciated.

Yours faithfully,


(Dr. Maxwell A. Asumeng)
HEAD OF DEPARTMENT

COLLEGE OF HUMANITIES

P. O. Box Lg 84, Legon, Accra-ghana

• Telephone: +233 (0) 289 550 463

• Email: Psychology@ug.edu.gh

• Website: www.ug.edu.gh

APPENDIX D
QUESTIONNAIRES

SECTION A

Socio-demographic Survey of Respondents

1. Gender: Male Female

2. Age: (in years)_____

3. Marital Status: Single Married Divorced
 Widowed cohabiting

4. Religion: Christianity Islamic Traditional
 Other (specify)_____

5. Level of Education: No Education Primary J.H.S
 S.H.S Tertiary

6. Years of education (state)_____

7. Ethnicity: Akan Ga/Adangbe Ewe Mole-Dagbani
 Other (Specify)_____

8. Region: Ashanti Brong-Ahafo Greater Accra

9. Type of Practitioner: Traditional priest Herbalist Imam
 Prophet/Prophetess Other(specify)_____

10. Years of Practice: (state in years)_____

SECTION B

ATPS

This part of the questionnaire examines your attitude towards patients with schizophrenia.

Read the following and indicate whether you 1= “Strongly agree” 2= “agree” 3= “partly agree”
4= “partly disagree” 5=“disagree”6= “strongly disagree”

Items	1	2	3	4	5	6
1. People with schizophrenia can never reach a good quality of life.						
2. People with schizophrenia are dangerous more often than not.						
3. The public does not need to be protected from people with schizophrenia.						
4. I think schizophrenia is a chronic illness.						
5. Schizophrenia is set off primarily by a disease in the brain						
6. Schizophrenia is set off primarily by relations in the family						
7. Schizophrenia is primarily set off by serious trauma						
8. Schizophrenia is primarily set off by genetic predisposition						
9. Schizophrenia is primarily set off by a combination of the mentioned factors.						
10. Professional mental health practitioners know more about the lives of people treated for a mental illness than do family members or friends.						
11. The way I see patients with schizophrenia influences my opinion about the possibility for recovery.						
12. It is important that if I am supporting a person with schizophrenia I have to also assess their physical health.						
13. It is important that any health/social care professional supporting a person with schizophrenia also ensures that their physical health is assessed.						
14. If a person with schizophrenia complained of physical symptoms (such as chest pain), I would attribute it to their mental illness.						

15. I just learn about mental health when I have to, and would not bother reading additional material on it.						
16. I feel as comfortable talking to a person with schizophrenia as I do talking to a person with a physical illness.						
17. I use terms like crazy, mad etc. to describe people with schizophrenia who I see in my work.						
18. If a colleague told me he or she had schizophrenia, I would still want to work with him or her.						
19. If I had schizophrenia, I would never admit this to any of my friends because I would fear being treated differently.						
20. If I had schizophrenia, I would never admit this to my colleagues for fear of being treated differently						

SECTION B

ATCI

This part of the questionnaire examines your views and opinion concerning collaboration with professional practitioners (such as clinical psychologists and psychiatrists) Read the following items and indicate whether you 1 = ‘strongly disagree’, 2 = ‘disagree’, 3 = ‘neither agree nor disagree’, 4 = ‘agree’ and 5 = ‘strongly agree’

Items	1	2	3	4	5
1. The communication between myself and lay mental health practitioners is open and honest.					
2. Lay mental health practitioners are open to working together with me on patients’ schizophrenia management.					
3. Lay mental health practitioners also deliver some level of quality healthcare to schizophrenic patients.					
4. I make time to discuss with lay mental health practitioners on matters relating to schizophrenic patients’ treatment regimens.					
5. Lay mental health practitioners meet the lay expectations I have of them to some extent.					
6. I can trust the lay mental health practitioners’ decisions on schizophrenic care.					
7. Lay mental health practitioners actively address schizophrenic patients’ treatment concerns.					
8. Discussions with lay mental health practitioners help me provide better patient care.					
9. Lay mental health practitioners and I have mutual respect for one another on a lay level.					
10. Lay mental health practitioners and I share common goals and objectives when caring for schizophrenic patient.					
11. My role and the lay mental health practitioners’ role in patient care are clear.					
12. I have confidence in the lay mental health practitioners’ expertise.					
13. Lay mental health practitioners believe that I have a role in assuring treatment safety.					
14. Lay mental health practitioners believes that I have a role in assuring treatment effectiveness					
15. My working together with lay mental health practitioners benefits the patient.					

SECTION C

ATCI

This part of the questionnaire examines your views and opinion concerning collaborative with Lay mental health practitioners (such as pastors, traditional priests, herbalists and mallams)

Read the following items and indicate whether you 1 = ‘strongly disagree’, 2 = ‘disagree’, 3 = ‘neither agree nor disagree’, 4 = ‘agree’ and 5 = ‘strongly agree’

Items	1	2	3	4	5
1. The communication between myself and professional mental health practitioners is open and honest.					
2. Professional mental health practitioners are open to working together with me on patients’ schizophrenia management.					
3. Professional mental health practitioners also deliver some level of quality healthcare to schizophrenic patients.					
4. I make time to discuss with professional mental health practitioners on matters relating to schizophrenic patients’ treatment regimens.					
5. Professional mental health practitioners meet the professional expectations I have of them to some extent.					
6. Professional mental health practitioners actively address schizophrenic patients’ treatment concerns.					
7. Professional mental health practitioners actively address schizophrenic patients’ treatment concerns.					
8. Discussions with professional mental health practitioners help me provide better patient care.					
9. Professional mental health practitioners and I have mutual respect for one another on a professional level.					
10. Professional mental health practitioners and I share common goals and objectives when caring for schizophrenic patient.					
11. My role and the professional mental health practitioners’ role in patient care are clear.					
12. I have confidence in the Professional mental health practitioners’ expertise.					
13. Professional mental health practitioners believe that I have a role in assuring treatment safety					
14. Professional mental health practitioners believe that I have a role in assuring treatment effectiveness					
15. My working together with professional mental health practitioners benefits the patient.					

STPS

This scale is developed to measure stigma towards practitioners who treat schizophrenia. Participants are to indicate whether they agree or disagree with each of these statements on a five-point Likert scale ranging from “Strongly agree” to Strongly disagree” where “Strongly agree”=5 , “Agree” = 4,

Items	5	4	3	2	1
1. Sometimes I feel that I am being talked down to by other health professionals because of my specialty in the care of patient with schizophrenia.					
2. I do not feel bad about specializing in schizophrenic care.					
3. I have been discriminated against by my employers because of my specialty in schizophrenic care.					
4. I worry about telling people I give psychological treatment of schizophrenia.					
5. Other people have never made me feel embarrassed because of my care for patients with schizophrenia					
6. I have been discriminated against by other health professionals because of my specialty in schizophrenic care.					
7. People have insulted me because of my care for patients for schizophrenia.					
8. I feel the need to hide my care of schizophrenic patients from my friends.					
9. I am angry with the way other colleagues have reacted to professionals who treat schizophrenia.					
10. I have been discriminated against in education because I treat schizophrenia					
11. Sometimes I feel that I am being talked down to because I give schizophrenic care.					
12. Having given schizophrenic care has made me a more understanding person.					
13. I do not feel bad about having chosen to give schizophrenic care.					
14. Some people with schizophrenia are dangerous.					
15. I have been discriminated against by police because I give schizophrenic care.					
16. Treating people with schizophrenia has made me more accepting of other people.					
17. Very often I feel alone because of my care of schizophrenia.					

18. I am scared of how other people will react if they find out that I give schizophrenic care.					
19. I would have had better chances in life if I had not chosen to care for people with schizophrenia.					
20. I do not mind people in my neighbourhood knowing that I treat people with schizophrenia.	5	4	3	2	1
21. I would say I give schizophrenic care if I was applying for a job.					
22. I worry about telling people that I give medicines/tablets for schizophrenia					
23. I have not had any trouble from people because of my care of schizophrenia.					
24. I have been discriminated against by other health professionals because I give schizophrenic care.					
25. Having treated people with schizophrenia has made me a stronger person.					
26. I do not feel embarrassed because I give schizophrenic care.					
27. Having had contact with people with schizophrenia makes me feel that life is unfair.					
28. I find it hard telling people I treat schizophrenia.					

In-depth Interview Guide

1. Understanding of mental illness among Lay Mental Health Professional
 - a. How do you understand mental illness?
 - b. Where do you get the knowledge you have on mental illness from?
 - c. How does your knowledge of mental illness influence your treatment practices for people with mental illness?
2. Understanding of schizophrenia Among Lay Mental Health Professional
 - a. What do you know about schizophrenia?
 - b. Where do you get all the knowledge you have on schizophrenia from?

- c. How does your knowledge of schizophrenia influence your treatment practices for people with mental illness?
 - d. How do you diagnose schizophrenia?
- 3. Views and Opinions on Collaboration for Schizophrenic Care
 - a. What are your views and opinions concerning different practitioners collaborating to provide schizophrenic care?
 - b. Which kind of collaboration (cooperation, Incorporation and total integration) will you be willing to work with and why?
 - c. Which role would you want to be playing in the collaborative care model?
 - d. What challenges do you foresee in the attempt at collaborative care model for dealing with schizophrenia?
 - e. How best do you think these challenges can be dealt with?
- 4. Do you join any association based on your practice?
 - a. If yes, is the name of the association?
 - b. What does the association do for your group of practitioners?
 - c. Does the association have any regulation concerning collaborative care?
- 5. Any other comment?

