

**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
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QUALITY OF MENTAL HEALTH CARE AT THE SUNTRESO GOVERNMENT

HOSPITAL

BY

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DECLARATION

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at the School of Public Health, University of Ghana or any other educational institution, except where due acknowledgment is made in the thesis.

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Date

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Date

DEDICATION

This work is dedicated to my parents Mr and Mrs Nsiah and my husband Mr Asare Boateng and my sister Mrs Eunice Adomako Acheampong whose inspiration and support has brought me this far. Also, to my group study mates who help in contributing to this success.

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ABSTRACT

Background: Mental health disorder is a subtly debilitating non-communicable disease requiring formal and informal caregivers to actively participate in its treatment and recuperation. But the onus is on the formal caregivers (health professionals e.g. nurses, doctors) to render satisfactory quality health service to the diseased (mental patient). This study was carried out to assess the quality of healthcare delivered to mental health patients from caregivers perspective at Suntreso Government Hospital.

Objectives: To evaluate caregivers' perception on quality of care mental ill patients received; to examine the effect of socio-demographic characteristics of caregivers on quality of care for mental patients and to describe the challenges that confront quality of care mental patients received.

Methods: This was a facility based descriptive cross-sectional study design. Chi square analysis was used to assess the association between the dependent variable (quality of care) and each independent variables (caregivers' perception of quality of care). Quality of care is defined as a person's evaluation of clinical care, effectiveness of clinical care and effectiveness of interpersonal care. Variables in bivariate analysis was fitted in the final multiple logistic regression model to describe the strength of association. Both Crude Odds Ratio (COR) and Adjusted Odds Ratio (AOR) with 95% confidence interval (CI) was used to show an association between the dependent variable and each independent variables. Proportions was used to measure challenges that confront quality of care from the perspective of caregivers

Results: There was no significant association between perception of care and quality of care delivery ($p>0.05$). Not discriminating against mentally ill patients correlates with quality of care delivery ($\chi^2=17.5687$; $p=0.000$). Showing respect to caregivers and mental ill patients has significant association with quality of care delivery ($\chi^2=17.5687$; $p=0.000$). Caregivers who earned more than 1000 GHS on monthly basis were 4.82 times more likely to perceive the quality

of service as good. Muslims were 0.11 times higher to be satisfied with quality of care provided to the mental ill relatives as compared with Christians.

Conclusions: Caregivers studied in Suntreso Government hospital showed poor perception on the quality of care the hospital provides for their patients (relatives). Also, caregivers' age, educational attainment, marital status and employment status did not influence their perception on quality of care delivered to their patients. There are variations in the challenges/barrier that confronts quality of care at the facility. Among these barriers are unavailability of drugs, lack of mental health specialists and lack of hospital beds.

Key Words: Quality of care, caregivers, health professionals

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LIST OF ABBREVIATIONS

AOR	-	Adjusted Odds Ratio
CI	-	Confidence Interval
COR	-	Crude Odds Ratio
LMICs	-	Low- and middle-income countries
MOH	-	Ministry of Health
mhGAP	-	Mental Health Gap
RIAS	-	Roter Interaction Analysis System
UK	-	United Kingdom
WHO	-	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

The World Health Organization (WHO) evaluates that about four hundred and fifty million individuals experience a psychological issue (WHO, 2011). Accordingly, the WHO has supported mental health as an all-inclusive human right and a key objective for medicinal services frameworks in every nation (WHO, 2005). The standards of primary health care at the Alma-Ata Declaration concentrated on social equity and the privilege to a better wellbeing for all, reiterating the WHO's all-encompassing method to realizing better wellbeing and the significance of primary care. WHO World Health Report (2008) contends that a 'rebirth' and revitalization of primary care is critical now, like never before, as mental health issues which constitute fourteen percent of the worldwide cases of disease being one of the main sources of ill health around the world.

World Health Organization explained mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community" (WHO, 2011). From the definition, mental health is surmised as any condition that makes it difficult for a person to adapt to ordinary worries of life, or condition of mental and social disequilibrium.

The causal agents for mental illnesses, are not totally comprehended or recognized. Numerous ailments, for example, coronary illness, result from an exchange of hereditary, social and different variables, and it has been propounded this may likewise be the situation for mental health situations too. Researchers do not comprehend every component important to bring

about mental health, yet every one of the instruments of present day biomedical research are being utilized to look for qualities, basic minuses in mental health, and different elements that may prompt the ailment (PsychCentral, 2006).

The mental condition which has a solid hereditary element, seems to influence around one percent of individuals around the world (McLaughlin, 2004). Individuals that are affected constitute a huge part of all occupants of mental organizations before and still do, where these establishments keep on existing (WHO, 2001). An expert healthcare intermediary and focused on treatment is required as a result of its staggering signs (Hamsley, et al 2012). In the early stage, individuals with mental disorder regularly appear to be unusual, unmotivated, emotionless, and antisocial. They confine themselves, begin disregarding their appearance, say particular things, and demonstrate a general lack of concern to life. They may surrender interests and exercises, and their execution at work or school disintegrates (Ofoedu, 2015).

Health facilities are set up to give extensive care to individuals who are enduring either physically, mentally or emotionally (Walsh & Crumbie, 2007). Health centers provide care, both remedial and preventive to individuals (Coughlin, 2012; Shattell, 2002). Since most patients enter a health center with a considerable measure of uneasiness, it is normal that their communication with the medical attendants and other health experts will fill in as one of the numerous methods for easing nerves, taking care of medical issues and aiding in accomplishing fulfillment (Radtrek, 2013; Neville, et al. 2012; Watson, 2005). To give the requisite care includes the joint effort between the sick or invalid and the health expert giving the care (Westbrook, et al. 2011). This joint effort requires different exchanges, for example, exchanges among doctors, exchange among doctor and nurse, exchange between doctor and patient and nurse-patient exchanges etc. These exchanges are required to help give a smooth and an all-

around care at the health center (Shattell, 2004). As indicated by Peplau (1952), relational relationship is a vehicle for the footing of a trust amongst patients and health professionals.

In Ghana, mental health is still in its earliest stages in terms of development and resources. For instance, there are no specialists in mental health for primary medicinal services, and in 2008, there were just 10 clinical psychologists, 13, 074 mental health specialists to Ghana's 24, 250, 438 populace in Ghana (Doku, et al 2012; Ofori-Atta & Ohene, 2015). This circumstance has made guardians/caregivers the principle providers of care for patients with mental health disorders (Chien & Wong, 2007). At the Suntreso hospital, mental health patients are left at the mercy of mental health nurses who are not specialized to provide specialized services. There is however a routine check on mental ill patients at the facility once every one week. This situation has rendered caregivers the sole providers of support to patients they are related to. It is based on this backdrop that the present study sought to assess quality of mental health care at Suntreso government hospital in the Ashanti Region of Ghana.

1.2 Problem statement

All over the world, there is a huge disparity between the level of mental health requirements and the accessibility of quality health care services to fittingly tackle these requirements. In low-and middle income countries (LMICs), in Africa as somewhere else, it is evaluated that seventy six to ninety nine percent of individuals with genuine mental issues cannot access the required treatment for their mental health issues (WHO, 2004; Mental Health Gap [mhGAP], 2008).

WHO report (2011) on mental health showed that in Ghana, out of the twenty-five million individuals living in Ghana, six hundred and fifty thousand were experiencing extreme mental issues and two million one hundred and sixty six thousand were experiencing moderate to mellow psychological conditions. While the ‘weight’ of mental health is a general public health concern around the world, a huge gap exist between the level of mental health needs and the accessibility of quality health care services (Neville, et al. 2012; Hermanns & Mastel-Smith, 2012). Besides, Marek (2003) posited that the presentation of free medicinal services for all at health centers in most emerging economies has reduced doctor to patient interaction and increased attendance. Health professionals feel pressurized into cutting down on time spent with their patients (Ministry of Health (MOH), 2009).

Research that examine the quality of care issues of mental health are hard to discover in literature (Awadalla, et al. 2005). Besides, a significant part of the studies on mental health, has been on examining shame, estimating guardian trouble and evaluating at policy issues concerning mental health (Doku, et al. 2012; Ofori-Atta & Ohene, 2015). However, no known study has quantitatively assessed quality of mental health care in Ghana from caregivers’ perspective. Since there is no known research into this area, this study aimed to fill this gap by examining the quality of mental health care at Suntreso government hospital.

1.3 Justification

The universal burden of illness linked to mental illness is on rise, with the World Health Organization forecasting that more than four hundred and fifty million individuals are affected around the world. As such, the Mental Health Global Action Program (mhGAP) was inaugurated by WHO in 2002 with a specific objective to address the broadening gap in access

to mental care in emerging economies. In spite of these endeavors, access to mental health care is still deplorable and is frequently portrayed as deficient, wasteful and unjust (Marangu et al. 2014).

Mental health disorder is non-transferable but requires caregivers to effectively take an interest in its treatment and recovery. However, the onus is on formal caregivers (health experts' e.g. medical doctors, nurses) to render quality services to the ailing. Though very little is known about the quality of care mental health patients in Ghana receive, this study is being carried out to describe the quality of healthcare delivered to mental health patients in Ghana by people who look after them.

The findings will make contributions in improving mental healthcare in Suntreso Government Hospital and the country as a whole. It will also make contributions by helping mental healthcare workers to promote the well-being of those seeking mental health care in health facilities in Ghana.

The findings of this study will also help inform Ghanaian policy and decision makers to formulate policies that will protect the health professional and patients' rights to prevent abuse. The Nursing and Midwifery Council of Ghana and can also benefit from this study to improve their curriculum, by making communication skills as part of practical licensing examination so that student nurses (mental health nurses) will be taught how to behave professionally toward mentally ill patients during their interaction.

1.4 Conceptual framework

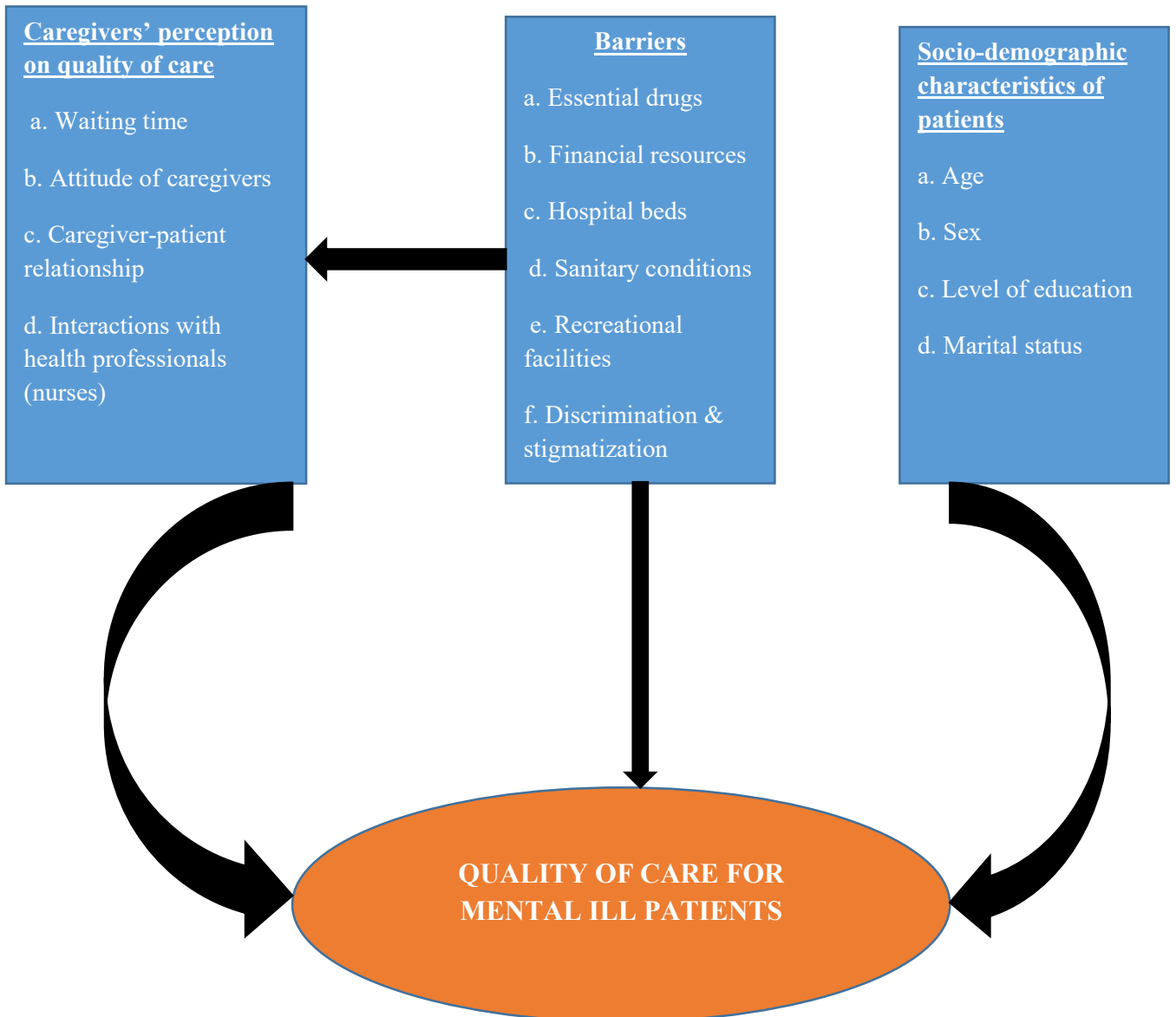


Fig. 1.1 Conceptual framework showing quality of mental health care

Source: Researcher's own construct (2018)

Description of conceptual framework

The socio-demographic characteristics of the patients comprising age, sex, marital status, and educational level are likely to influence the quality of care mental ill patients receive. The age

of patients has a role in the receiving quality services. The gender of patients are likely to influence care they receive. Being married before experiencing mental illness is likely to positively affect the quality of service rendered to patients as compared to the unmarried. Thus, one's spouse will provided the needed support via continuous visitation. Being educated will help patients in their recovery by adhering to medication and treatment. Patient characteristics such as age, gender and education level slightly influence patient satisfaction with quality of service (Shou-Hisa, Ming-Chin & Tung-uang 2003).

Furthermore, barriers such as stigmatization and discrimination, financial resources, availability of hospital beds, sanitary conditions and availability of recreational facilities are likely to affect the quality of care for mental ill patients. Stigmatizing and discriminating against mentally ill patients at hospitals are likely to influence the assistance and care given to mental patients. Under-resourced health institutions are likely to lack the basic equipment to provide the needed help to mental ill patients. The availability of standard beds are likely to provide the needed comfort for patients. Barriers such as comorbidity, stigmatization, lack of affordable mental health services, and a general shortage of human resources affect the quality of care for mental health patients (Corrigan, 2004).

The perception of guardians and/or caretakers of patients such as the time spent at the hospital to see patients, the attitude of health professionals towards caregivers and patients at outpatient and inpatient departments and the caregiver-patients relationship and interactions with patients are crucial to the quality of care mental ill patients receive. Patients' perception of quality of care revolved around being helped to reduce the shame of being a psychiatric patient and being looked upon like anyone else (Schröder et al. 2006).

1.5 Research questions

1. How does caregivers' perceive the quality of care given to mental ill patients at Suntreso Government Hospital?
2. Does caregivers characteristics influence quality of care for mental ill patients at Suntreso Government Hospital?
3. What challenges confronts quality of care for mental ill patients at Suntreso Government Hospital?

1.6 General objective

The general objective of the study was to assess the quality of care mental ill patients receive at Suntreso Government Hospital

1.6.1 Specific objectives

1. To evaluate caregivers' perception on the quality of care mental ill patients received at Suntreso Government Hospital.
2. To examine the effect of socio-demographic characteristics of caregivers on quality of care for mental patients at Suntreso Government Hospital.
3. To describe the challenges that confront quality of care mental patients received at Suntreso Government Hospital

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The chapter presents review of related studies on mental health from the perspective of caregivers in Ghana. The chapter reviewed literature on the burden, symptoms, causes and effects of mental illness, defines caregiving and caregiver. It further defines and explains the concept of quality of care; quality of care for mental ill patients is also reviewed, socio-demographic characteristics of patients; caregivers perception on quality of care and barriers to quality of care. The information reviewed are summarized and conclusions made.

2.1 Mental illness: burden, symptoms, causes and effects

Withdrawal from group activities, showing antagonistic traits, declining personal upkeep, bland look, failure to cry or express delight, wrong giggling or crying, dejection, sleeping late or a sleeping disorder, silly utterances, absent minded, extraordinary response to feedback and unusual utilization of words or method for talking as indicated by Smith and Segal (2013) are a portion of the early indications of mental illness (schizophrenia). While these notice signs can come about because of various issues, not simply schizophrenia, they are, as one, cause for concern.

The causal agents of mental illness are inadequately known. Nevertheless, there is significant amount of evidence suggesting that mental illness is both an actual brain disorder, which is normally due to a complex interaction between genetic and environmental factors (Smith & Segal, 2013). Lehman affirmed this by describing mental disorder, e.g. schizophrenia as traceable to both genetic and acquired factors, evidenced by the fact that the risk of

schizophrenia is about 50% in the identical twin of a person with the disorder, compared with only about 10-15 % in a non-identical twin (Lehman, 1999). Messias, Chen, & Eaton (2007) list complications during pregnancy and birth especially exposure to viral infections; extreme maternal deprivation during pregnancy; and perinatal delivery complications as other indirect non-genetic causes of mental illness.

Mental disorder can be destructive if not handled in the right manner. Smith and Segal (2013) list problems in relationship, interruption normal everyday activities, abuse of alcohol and drug and heightened suicide risk as some of the consequences associated to mental disorder. Key characteristic of mental illness, particularly schizophrenia, is cognitive dysfunctions; which has also been keyed out as a principal determining factor for life long result and quality of life (Sharma, 2003). Looking at how mental illness affects an individual's actions, thinking and perspectives, dependence on soothing care is almost mandatory, where caregiving outside the health facility becomes an important contribution towards the patient's recuperation.

2.1.1 Caregiving and the caregiver

Caregiving according to the LA Public Health is to give an everyday aid and support to people who cannot function on their own; either short-term or long-term (LA Public Health, 2010). Thus, an individual who executes undertakings for another individual, who on their own cannot execute their own undertakings because of their age or other health and developmental conditions, is referred to as a caregiver. This care is rendered either on the basis of employment agreement or other official arrangement or voluntarily (Goodhead & McDonald, 2007). From the above, it can be deduced that it is not distinctly defined who a caregiver is, as the difference in caregiving tasks executed has been considered a chief factor in defining who a caregiver is

(Wood, 1991). The condition under which the care is given defines the caregiver as formal or informal.

Informal caregivers are normally family members or close relations of the recipient; thus informal caregivers receive no payment for the services they render (Schulz & Sherwood, 2008). Though informal caregivers are naturally expected to give attention to their family members or friends, the attention referred here goes outside usually expectations to include some reference to strange dependence by the recipient mostly because of a medical condition, such as mental disorder (schizophrenia) (Hermanns & Mastel-Smith, 2012). On the contrary, formal caregivers have formally been trained in the care they provide to others and they receive payment for rendering such care (Waldrop, 2006). Informal caregivers are mostly females. In all likelihood, low and middle income earners, rural dwellers as well as uneducated individuals become informal caregivers (Bresnick, 2013; Janner & Delenay, 2012; Hamsley, et al 2012).

The duty of a caregiver, particularly, that of a mentally ill person, is intermixed with agonizing burden in different forms, ranging from physical and emotional stress, social stigma to socioeconomic costs. Caregiving for mental disorder patients mostly include aid with tasks of everyday living, ongoing monitoring, liaising with formal care systems, and attending to any shortfall not provided by paid health care workers among others (Goodhead & McDonald, 2007). According to the World Health Organization, about 40%-90% of patients with schizophrenia live with their families worldwide (World Health Organization, 2008). However, current alterations in family structures and rapid economic fall in several developing countries are jeopardizing such family support available to patients with chronic mental illness (Yusuf, Nuhu, & Akinbiyi, 2009).

2.1.2 Quality of care

Performance measurement is very important with respect to all clinical practice and one of the criteria used to understand such framework is the quality of care. The quality of care as an idea here goes outside simple service quality. Nevertheless, its reach and embedded components are still debated subjects. In realizing its girth, it is necessary to then know what it is of itself.

Essentially, there may be variations in “quality of care” from country to country or at least from culture to culture (Aldana, Piechulek, & Al-Sabir, 2001). The difference can also be on the basis of simply clinical-based notion or a broader one which is based on stakeholder priorities. There are lots of definitions for quality in relation to health care and health system, and other areas of activities.

One of definitions of quality of healthcare is given by Campbell, Roland and Buetow and according to them quality of healthcare is chiefly a person’s evaluation of clinical care, effectiveness of clinical care and effectiveness of inter-personal care. With regard to population health, quality of care should include efficiency and equity; taking into consideration variations in cultural/national comprehension of care (Campbell, Roland, & Buetow, 2000).

Donabedian (1966) defined care of high quality as “that kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts.” The American Medical Association defined high-quality care as care “which consistently contributes to the improvement or maintenance of quality and/or duration of life” (Blumenthal, 1996).

The United States Institute of Medicine defined quality of health care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Mitchell, 2008)”. Definitely, these definitions of quality of care have two essential components, technical quality in which all medical procedures are conducted with the mind-set that health benefits exceed risks and inter-relational care in which patients expect to be treated in a humane and culturally, sensitive way (Brook, McGlynn, & Shekelle, 2000).

2.1.3 Quality as a multi-dimensional concept

Quality of care as a multi-dimensional concept depends on the correlation between what patients expects (influenced by culture and value systems) and the experiences they go through within clinical care. It is generally assessed on three dimensions, developed by Donabedian (1966) of the structure of the health care organization or system (including community, individual and provider characteristics), the process of the delivery of needed health care (which assesses content and method of care based on practice guidelines), and the outcomes (which could be clinical, functional or attitudinal) for the consumers of those services.

The six spheres of quality advocated by WHO for which all health system must concentrate on bettering is addressed in this concept (World Health Organization, 2006): (1) Effectiveness - delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need; (2) Efficient - delivering health care in a manner which maximizes resource use and avoids waste; (3) Accessible - delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need; (4) Acceptable/Patient-centred - delivering health

care which takes into account the preferences and aspirations of individual service users and the cultures of their communities; (5) Equitable - delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status and (6) Safe - delivering health care which minimizes risks and harm to service users.

Throughout history, quality of care has been given less priority by health planners and policy makers in developing countries like Ghana, due to more emphasis being placed on coverage, perception of cost-intensiveness of quality improvement and the difficulty in assessing quality (Reerink & Sauerborn, 1996). However, change is being effected and one of the reason for the change is because of initiatives and agenda like the Sustainable Development Goals which have quality centred output measures, the need to ensure value for health investments, increased uptake of services available and the need to ensure that care quality keeps pace with accelerating medical technology improvements (Graham et al., 2000; WHO, 2006).

2.1.4 Quality of care for mental ill patients

There are a lot of treatment methods for schizophrenia; salient ones include pharmacotherapies, psychological treatments, family interventions, vocational rehabilitation, and case management and assertive community treatment. Every one of the treatment method calls for particular quality guidelines. These range from standards on efficacy, to treatment focus, cost-effectiveness, family education, family-staff inter-relationship, patient-skill acquisition and prescription practice (Lehman, 1999). A large number of factors influence the ensuring of quality of car for individuals with schizophrenia. Few among these factors are: inability to lucidly communicate with providers due to social and cognitive skills, fearfulness (paranoia),

discomfort of health providers in treating the mentally-unhealthy person and the stigma attached (Druss, 2007). Also quality of care given to individuals who are mentally unhealthy is affected by gender, education and age (Young, Klap, Sherbourne, & Wells, 2001).

Good psychopharmacology and case management are necessary for quality of care given to individuals with mental illness. This is revealed in a study where practice guideline developed by clinicians and academic researchers on evidence-based knowledge remains relevant in guiding a defined care quality (Tunner & Salzer, 2006). This knowledge notwithstanding, it is very well acknowledged that conditions for quality of care for individuals with schizophrenia are clearly poor and this has been so for some time, with social inequalities causing it declining (Horvitz-Lennon *et al.*, 2014; Young, *et al* 1998). Horvitz-Lennon *et al.* (2009) discussed quality of care in the context of institutional systems, where quality was considered in terms of increased cost of treatment, financial access to treatment/drugs, workforce certification and regulatory framework to highlight how multi-varied the indicators of quality of care for schizophrenia was (Horvitz-Lennon, *et al.* 2009). According to Akpalu *et al.* (2010), quality of care in Ghana is comprehended as human and material resources deficiency and over-crowding of hospital facilities and not the inter-personal relationship between provider and the client (Akpalu *et al.*, 2010).

2.1.5 Measures of quality of care

With these pointers of quality of care, for example, waiting time, accessibility of data, caregiver exposure to the quality of care, it is near impossible to rank the significance of these pointers or build any measure of quality of care (Donabedian, 1988). The encounters by caregivers informs their perception and satisfaction with the quality of care and are subject to

three essential issues of medical care framework as pointed out by Saxena, (2007). These comprised; caregivers views on the benefits of quality of care of medical care; great provision of care by medical facilities and efficient medicinal services association (Chakraborty & Majumdar, 2011). The connection between the quality of care and satisfaction of consumers [in this case the quality of care and caregiver], is in the view of caregivers on the type of services received; this informs caregivers satisfaction with services received (Andaleeb, 2005). Mitchell (2008), called attention to the demerits on estimating quality of care as the propensity for pointers created to quantify mortality, illness, incapability, distress, and displeasure instead of more positive pointers of quality.

In estimating quality of care, the process of quality of care forms have been recognized as both exterior and interior with a measure in view of the kind of care being given. A research on the quality of care in an emergency unit showed that absence of information, inability to acknowledge clinical earnestness, absence of supervision, and inability to look for counsel as reasons for the provision of quality care (McQuillan et al., 1998). A worldwide investigation of quality of care in different intensive care units in a hospital demonstrated that quality of care was reliant on satisfactory staffing and administrative assistance for health personnel are critical to enhancing quality of care (Aiken, Clarke & Sloane, 2015). In general, quality of care can be estimated with pointers that might be centered around any of the three measurements it covers, for example, a procedure measure utilized as a part of studying quality of care for patients in the US (Hermann et al., 2002) and a regulated measure in Italy among schizophrenics also (Bollini et al., 2008).

In mental health settings, tools that have been produced are for the most part quantitative devices, for example, the 10-thing Rome Opinion Questionnaire for Psychiatric Wards given to in-patients of mental wards, “The Practice Environment Scale of the Nursing Work Index Revised” for medical attendants in mental wards, “Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations”, “Quality Assessment of Regional Treatment Systems for Schizophrenia” (QUARTS), the “American Psychiatric Association's Practice Guideline” for management of mental illness, the “US Clinical Practice Guidelines for Psychosis Treatment”, and the “Expert Consensus Guidelines” for the management of mental illness (Hanrahan & Aiken, 2008).

2.1.6 Perspectives of quality of care

As far as perceptions are concerned, quality of care is seen contrastingly by customers (whose perspectives underscore the human part of care and are impacted by socio-social concerns), health personnel (who accentuate the requirement for structural capability and strategic authoritative help), program supervisors (who center around coordinations, record-keeping and supportive networks) and policymakers/benefactors (more inspired by cost, productivity and results for their venture) (D'Ambruso, Abbey, & Hussein, 2005).

This investigation centered on the perception of non-therapeutic guardians (particularly caregivers) for patients who are minors or not rationally capable to have the capacity to normally evaluate the nature of care they get. It ought to be noticed that even in view of same issues of quality, patients and their families have appeared to have contrasting viewpoints on the significance of such issues (Tunner & Salzer, 2006).

Socio-economic status (SES) and related conditions may incline one to mental illness, and correspondingly, existing mental ailment may cause monetary hardship, in this way affecting a person's socio-economic status (Hudson, 2005). Past research has discovered that among low-socio-economic youth, parental history of abusing hard drugs, or psychological issues appeared to be regular encounters, and in that capacity are indicators of psychological discrepancy and social issues (Burke, Peper, Burrows, & Kline, 2004). The lack of housing, or its rareness has additionally been related with psychological issues, among the youth (Clark, Squire, Heyme, Mickel, & Petrie, 2009). Moreover, accommodation issues and/or lack of permanent residence increase the likelihood of being arrested and imprisoned which could additionally underestimate the youth as it has effect on their future in terms of work, accommodation, education, and social integration (Glasberg, 2007).

Detention and imprisonment have a mind boggling association with psychological well-being, thus, detention might not be prescient of psychological issues, but rather might be an aftereffect of an undiscovered psychological issue (James & Glaze, 2006). Across racial and/or ethnic lines, access to mental health services is unevenly distributed with White youth having more access to hospitalization and medicinal services compared to African American youth (Bishop, 2014). Ongoing National Health Behavior Survey (NHBS) information demonstrate that among MSM, Black men report higher detention rates than White MSM (Lim, Sullivan, Salazar, et al., 2001). Detained youth, or youth who have experienced the criminal equity framework, tend to show higher rates of psychological maladjustment (Fisher Roy-Bujnowski & Grudzinskas, 2011). Racial/ethnic minority youth encounter disproportionality higher rates of detention, suggestive of further stigmatization (Fisher et al., 2011).

Among the youth in the US, records show racial/ethnic inconsistencies in psychological health issues. As per the Surgeon General's Supplement on Mental Health (USDHHS) (2001), the incidence of psychological wellness issue among the youth living in the same community is practically identical between racial/ethnic minorities and whites. Be that as it may, this finding does not have any significant bearing to the defenseless, high-require subgroups, for example, people who are destitute, imprisoned, or regulated where racial/ethnic minorities are overrepresented (USDHHS, 2001). Stress linked with prejudice and separation has additionally been connected to poorer psychological issues results among racial/ethnic minorities (Williams, Yu, Jackson, et al., 1997). Last but not least, minority groups that have less access to mental health care, are less inclined to get this care, and get poorer quality of psychological well-being care (USDHHS, 2001).

2.2 Socio-demographic/economic characteristics of caregivers and quality of care

Larrabee and Lois (2001) conducted a study on “defining caregivers perceived quality of nursing care”. From the data they gathered, they concluded that patients’ judgements about attributes of multidimensional model of patient’s satisfaction are affected by socio-demographic or personal variables. According to Avis and Band (1995), caregiver satisfaction is significance when patients examine their experience with expectations. Studies reveal a correlation between mental treatment and a better economic outcome (Lund *et al.*, 2011). In addition, a firm relationship was discovered to exist between the percentage of people with mental illness and countries with unequal income (Pickett & Wilkinson 2010).

Caregivers perspectives on nature of care to a great extent contrast in various wellbeing focuses and more established guardians respect nature of care higher than more youthful guardians

(Kvist et al., 2013). Two investigations, one led in Scotland whereby six hundred and fifty patients released from four intensive care facilities in amid February and March 2002, and the second examination was led in thirty-two distinctive tertiary clinics in the USA, uncovered that male patients, patients more established than 50 years old, patients who had a shorter length of stay or better wellbeing status and those with essential level instruction had higher scores identified with variable wellbeing administration related areas (José, Nerea, Amaia et al. 2006; Otani, Herrmann, and Kurz 2011). On the contrary, a nation-wide study in various recognized clinics in Taiwan showed that caregivers attributes, for example, age, sexual orientation, and current education status has low influence on caregiver satisfaction but caregivers' health statuses greatly influence caregivers' total satisfaction (Shou-Hisa, Ming-Chin and Tung-uang 2003).

Besides, studies by Nguyen et al. (2002) and Jenkinson et al. (2003) outlined maturity and better wellbeing status as the two most grounded and most steady determinants of higher satisfaction. Two other studies however gives opposite results with respect to the influence of the controlled elements, age and sex on the aggregate caregiver satisfaction in various parts of human services administrations (Tonio, Joerg, & Joachim 2011; Rama & Kanagaluru 2011). Contrastingly, a nation-wide study conducted in sixty-three clinics in 5 health provinces of Norway in 2006 revealed that age, sex, apparent health and education status had little influence on overall caregiver satisfaction (Oyvind, Ingeborg, & Hilde 2011).

From the above (section 2.2), it was deduced that the effect of socio-demographic characteristic of caregivers on quality of care for mental ill caregivers is inconclusive. This study sought to

add to literature by assessing the effect of caregivers socio-demographic characteristics on quality of care given to mental ill caregivers.

2.3 Caregivers' perception of quality of care

The fundamental function of any health system is to ameliorate health and render services that are forthcoming and affordable, while properly treating people (WHO, 2004). Caregivers, recipients of healthcare, are depended on to assess interventions for different disease conditions and experientially, offer their views on the quality of healthcare given them. These obviously stated ideals necessitate a consistent betterment of delivery coverage and quality of the systems. Williams, in validating this idea reported that satisfaction of caregivers on the basis of quality of care lied on inexplicit assumptions on the nature and meaning of satisfaction, and identifying the ways and terms in which caregivers perceive and assess health care as the initial step in evaluating the quality of care (Williams, 1994).

A study in Toronto, Canada, that sought to point out the gap in best healthcare principles and actual practices, made an empirical argument for integrating stakeholders, especially caregivers and caregivers, in a collaborative process of decision-making on care quality. The study further asserts that this approach can be beneficial to all by meeting the expectations of caregivers while ensuring continuous service improvement in the health organization (Culyer, 2004).

Healthcare literature coming forth indicates that caregiver satisfaction is a prevalent worry which is interlaced with strategic decisions in health services with evidence showing the existence of a relationship between perceived service quality and satisfaction, and also the

inter-relationship between caregiver and staff (Gilbert, Lumpkin, & Dant, 1992). A study conducted in Sunyani Regional Hospital, revealed that caregivers were satisfied with communication. However, more improvement is needed in the area of interrelationship; this limit the quality of care caregivers enjoyed (Peprah & Atarah, 2014).

A study conducted in France among cancer caregivers undergoing ambulatory chemotherapy emphasized that assessment of caregivers' satisfaction is an essential criteria use to evaluate quality of care (Nguyen et al., 2011). In another study, comparison was made for selected results of a new chronic disease management programme which involved caregivers' addition with those of an existing model of care. This study revealed the importance of caregivers' views on health care services through a complementary team approach to chronic disease management (Litaker et al., 2003).

Among caregivers in a radiology department in Umea, Sweden, it was shown that caregivers' dissatisfaction with health services particularly in the areas of lack of information on waiting times, poor interaction with caregivers and not sending appointment notices in adequate time before examination were more likely to have a perceived low quality of care (Blomberg, Brulin, Andertun, & Rydh, 2010; Hall, 2013). A longitudinal study of quality of care in Zaire (now DR Congo), showed that a holistic view of quality of care was necessary, as caregivers' perception did not only include technical and organisational quality components, interpersonal and access (cost) components were equally important (Haddad & Fournier, 1995).

In another study where the results of mental health interventions were examined among psychiatric caregivers further revealed caregivers' perception as a criteria of quality (Costa, et

al. 2011). In psychiatric settings, Schröder (2006) discovered that caregivers' views of quality of care centres on help received to minimize stigmatization and being seen as every other person. Schröder (2006) further explained that caregivers had a good disposition towards the idea of good quality of care, which they measured by the staff respecting the dignity of the caregiver, the caregiver feeling secured in the ability of the staff to care for them, the caregiver participating in such care, the care being performed in a supportive environment and the caregiver ultimately recovering.

A qualitative study conducted among schizophrenia caregivers on the quality of care revealed that though there is wide agreement on the significance of proper case management and psychopharmacology, there is also substantial revelation of the significance of interpersonal process and the need for psychosocial rehabilitation supports (Tunner & Salzer, 2006). A confirmatory study conducted on individuals with mental disorder and diagnoses of schizophrenia also showed that caregivers graded care quality by elevated chance to resist feelings of vulnerability and alienation with a sense of connection that was based on shared humanness with practitioners (identified in getting 'extra things,' looking for common ground, feeling known, the importance of talk, feeling like 'somebody,' practitioner availability, practitioner flexibility, and opportunities for input into treatment) (Ware, Tugenberg, & Dickey, 2004).

How caregivers view care quality influences people's usage of the care provided them. This is revealed in O'Brien, Fahmy and Singh's review where schizophrenia caregivers gave providers not being kindly, not being given an ear, inability to actively partake in decision making and

being disgruntled with services as reasons for non-usage care provided (O'Brien, Fahmy, & Singh, 2009).

However, it has been credibly argued that caregivers are not to be regarded as good judges when it comes to quality, with a problem depending on how caregivers view things and are totally sensory. This rests in the discovery that internal evaluation of caregivers may seriously be restricted by their social experiences (Sen, 2002). A study in 1988 by Peterson drew light on this. He disregarded caregivers' perception as very subjective, stating that it was unnecessary whether or not the caregiver is right or wrong and placed significance on how the caregiver felt with room left for the caregiver's different perception of quality of care (Andaleeb, 2001). Thus, quality cannot actually be attained if providers do not see caregivers as experts and equal partners, and the benefits of shared decision-making like greater adherence to treatment regimens, more effective disease self-management, better disease control, and greater caregiver satisfaction will not be attained (Kreyenbuhl, Nossel, & Dixon, 2009).

The proximal outcome of caregivers' satisfaction with communication was examined in an audio-recorded primary care visit between 564 adult caregivers and 59 physicians using the Roter Interaction Analysis System (RIAS). Findings showed that physicians' psychosocial communication (e.g., seeking psychosocial information) was connected positively to satisfaction (Paasche-Orlow and Roter, 2003). A survey conducted among 1,588 older diabetes caregivers revealed that physicians' giving information was connected to longer-term results of medication adherence and foot care (Heisler, *et al.*, 2007). The entire study suggested that a content constituent of finding and getting information tends to represent effective caregiver-physician communication. Evidence shows that how caregivers' view excellence in care is on

the basis of their perception of availability and visibility of nurses' level of knowledge or competence (Gurney, 2010; Woodard, 2009).

In furtherance, how caregivers' view the effectiveness of nurse-caregiver interaction at hospitals is dependent on the care caregivers need from their nurses. This implies that it is highly possible for caregivers to view their interaction with nurses as effective if they obtain high quality of care from the nurses. Lots of researchers have evaluated caregivers' satisfaction with nursing care in general terms, as well as caregivers' perceptions of the quality of nursing care (Wysong & Driver, 2009). Outcome of a qualitative study conducted by Wysong and Driver (2009), concentrated greatly on interpersonal skills of nurses than technical skills. All 32 participants focussed their discussion on the nurses' skills as the measure of judgement on whether nurses are skilful or not. In a similar manner, a review of the literature by Scandinavian researchers Johansson, Oleni and Fridlund (2002) points out that caregivers' satisfaction with nursing care is affected by the nurses' technical competence, as well as by the interpersonal relations between the nurses and the caregivers. A study in Iceland showed that nurses who are considered to give high-quality care were described by caregivers as kind, joyful, warm, polite, and understanding and as having clinical competence (Thorsteinsson, 2002). In another study in Iceland, clinical competence was however regarded the most significant nurse caring behaviour; that is know how to give shots and IVs, know what they are doing, know when to call the doctor, and know how to handle equipment were items with the highest scores (Zamanzadeh *et al.*, 2010). Technical skill was regarded the most significant, though recognition was also given to interpersonal skills for nurses to attain their objectives in care giving. The cooperation of the caregiver is needed if nurses are to attain much with their technical competencies.

A study was conducted in Ghana to examine the interactions of pregnant and newly delivered women with healthcare providers. The findings of the study showed that apart from cost and proximity of distance, perceptions of quality of care and staff behaviour were highly significant to the women's satisfaction with care provided. That is, they expected humane, professional and courteous treatment from health professionals and a reasonable standard of physical environment (D'Ambruso et al., 2005).

Perceptions are like noses and as such can be extremely subjective. However, treating everyone with courtesy and respect is universal in achieving quality health care. From the literature reviewed in section 2.3, the perceptions of respondents are crucial to the quality of care they receive at health facilities. This study added to literature by examining the perception of caregivers in the quality of care meted out to them in Suntreso Government Hospital when they visit their caregivers.

2.4 Barriers to quality of care

The right to health includes both physical and mental health, thus:

...efforts to recognize and uphold a human right to health must incorporate strategies to protect, respect, and fulfil mental health as well as physical health. Establishing and upholding affirmative mental health rights can fundamentally advance the dignity and welfare of persons with mental disabilities, and, simultaneously, advance the recognition and development of the right to health generally (Gable & Gostin, 2009).

Nevertheless, researches have revealed that individuals with mental disorder are mostly marginalized and discriminated and this is contrary to their enjoyment of the right to health

(Hunt, 2005; WHO 2001). There is a lot of hindrance – social and organizational –for example, comorbidity, slander, absence of moderate psychological disorder and a general lack of HR for psychological well-being care in numerous nations, adding to this (Corrigan, 2004).

Globally, about 430 million individuals are suffering from mental illness and other related consequences (Mental Health and Development 2012). The elevation of stigmatization and discrimination toward mentally ill individuals may place restrict their access to healthcare; thus aggravating their mental illness. Discrimination could not just limit admittance to psychological wellness but affect their compliance to treatment. A study revealed that HIV stigma had an impact on youth adherence to anti-retroviral therapy and 30 percent of the respondents skipped their medications in order not to find out about their status (Rao *et al.*, 2007). In a recent US study, the rate at which Active Duty and National Guard Soldiers who returned from Iraq used mental health services was examined. From the study, high level of stigmatization is linked to lower usage of mental health services (Kim *et al.*, 2010).

In many Arab countries, allotted funds and financial plans for mental health services remains inadequate. There are less than 0.3 mental health specialist for every one hundred thousand individuals in Sudan and six other Arab countries. Additionally, two Arab countries have no mental health policy while six do not have any legislation (Ahmed, & Tarek 2012). There is shortage of mental health professionals in low and middle income countries. It is necessary to include psychiatrists in managing programs and capacity building off other clinical staff so as to ameliorate mental health services and referral (Patel, 2009).

An examination was directed in the Niger delta (Nigeria) to assess the boundaries impeding the utilization of mental health from the point of view of caregivers. Result from the examination appeared there are monetary, physical, and social boundaries to the usage of mental health services including disgrace, poor information on mental health services, centralization of mental administrations, and holding up time. The research additionally surveyed caregivers socio-socioeconomics hindrances which could thwart access to psychological wellness administrations (Bruwer et al. 2011).

In South Africa, basic and attitudinal obstructions to mental health care were inspected together with the indicators of treatment dropout utilizing eye to eye interviews. Attitudinal boundaries, including the absence of saw requirement for treatment, disgrace, and the view of mental issue as an individual shortcoming were more generally announced by interviewees than auxiliary hindrances, for example, money related cost and absence of accessibility of administrations (Awenva et al. 2010).

Besides, inadequate budgetary and HR, absence of coordinated effort and discussion, and not being a need by strategy creators were perceived as boundaries to psychological wellness arrangement usage in Ghana (Awenva et al. 2010). Sudan has exceptionally constrained information, with just a research investigating the obstructions to the usage of emotional well-being administrations in the capital Khartoum from the viewpoints of medicinal services suppliers and arrangement creators (Abdelgadir, 2012). In this investigation, the measure of financing, dissemination and allotment of emotional wellness administrations, weakness training, the long length of treatment, and dread of shame were distinguished as hindrances to the usage of psychological wellness benefits in Sudan.

Aiken, Clarke, and Sloane, (2015) studied the factors that affect quality of nursing care in rural district hospitals in South Africa. While the study centred on the quality of nursing care, the outcome of the study revealed that doctors' availability played a crucial role in ensuring caregivers' safety and prevented putting them at risk. The study revealed that 76% of the participants indicated that insufficient availability of doctors create an ethical and legal dilemma and placed the caregiver's safety at risk. Ayuso-Mateos, *et al.* (2006) affirmed this when they found older caregivers to report their dissatisfaction in the quality of care. However, the study relied on recording the care to measure the quality of care provided rather than the care delivered. Ayimbillah Atinga, AbekahNkrumah, and Ameyaw, (2011) further found that poor doctor-nurse-caregiver communication had a deleterious effect on the caregiver's care provided.

A study in Burkina-Faso found that financial accessibility was itself a measure of quality of care as well as drug availability and technical quality (Baltussen, Yé, Haddad, & Sauerborn, 2002). This same conclusion on the impact of financial barriers on care quality has also been corroborated by various findings in Ghana (Nyonator & Kutzin, 1999).

In 2013, Can *et al.* assessed the factors which impacted on the quality of care in in South Africa. Despite the fact that the investigation concentrated on the nature of nursing care, the discoveries of the examination uncovered that availability of specialists medical staff assumed an essential part in furnishing caregivers with the security in terms of care delivery. The research found that seventy-six percent of the caregivers intimated that the lack of specialized medical doctors/personnel puts the safety of patients in danger. This is corroborated by Andaleeb (2005) who discovered that elderly patients are more likely to receive low quality of care.

There still are perceived difficulties to quality of care measures, for example, institutionalizing result measures, restrictions on current knowledge of assessing specialized quality, data asymmetry amongst supplier and patients and choosing the part of financial cost in such assessments (Cooperberg, Birkmeyer, & Litwin, 2009).

In Africa, quality of care is a critical determinant of medicinal services utilization, as perception of quality of care will determines demand for health care services. Estimating quality of care in the African setting, nonetheless, goes beyond measuring consumable sources of info and relationship between patient-health personnel. It covers client charges, access to supplier and other additional office markers (Mwabu, Ainsworth, & Nyamete, 1993). In any case, because of interventions like the Bamako Initiative, an indicator like fee-for-essential-drugs has enhanced quality of service (Haddad & Fournier, 1995). In any case, an examination in Burkina-Faso found that being financially apt was itself a measure of quality just like easy access to essential drugs and technical quality of care (Baltussen, Yé, Haddad, and Sauerborn, 2002). The conclusions arrived at corroborated by different researches in Ghana (Nyonator and Kutzin, 1999; Waddington and Enyimayew, 2009).

2.5 Chapter summary and conclusion

Caregivers' satisfaction is an accepted primary performance indicator in the evaluation of quality of care. With forth coming literature affirming the perception of quality of care by informal caregivers for ailing caregivers, especially for the terminally ill, it is vital to note that

there is yet to be a study evaluating the quality of care for mentally ill caregivers from the perspective of caregivers.

The focus of this research therefore was on the quality of care meted out to mentally ill caregivers. This study sought to contribute to filling this knowledge gap and to inform policy on areas that needs improvements.

CHAPTER THREE

METHODS

3.1 Study design

The study adopted a descriptive cross sectional study which used quantitative methods to assess caregivers perceptions on quality of mental health care at Suntreso government hospital.

3.2 Study area

The study was conducted at Suntreso government hospital (Figure 3.1). The Suntreso Government Hospital, is situated at the North-Suntreso region in Kumasi was set up in 1963 as an urban wellbeing center to give primary social health care to inhabitants of the Bantama metropolitan zone and its environs.

The hospital turned into a polyclinic in 1980 because of the huge extension in its operations and the huge increment in caregivers' turnout. As this proceeded, the Ghana Health Services in 1996, updated the center to a District clinic to empower it handle additionally difficult medical problems in the Bantama Sub-metro and its environs. The healing center and its exercises have since been stratified into two departments, Obstetrics and Gynecology and Sexually Transmitted Diseases offices. These departments are headed by specialized doctors. The clinic at present has staff quality of one hundred and forty-four which contain seven medicinal officers (MOs) and four medical officers (MAs), seventy-five general nurses, twenty-two community nurses and twenty-six mid-spouses.

The mental health department of the hospital has five mental health nurses who work on morning, afternoon and evening shifts. The department has a fifty beds capacity for patients with crucial needs but treats and provide psychiatry services to over 100 patients every week.

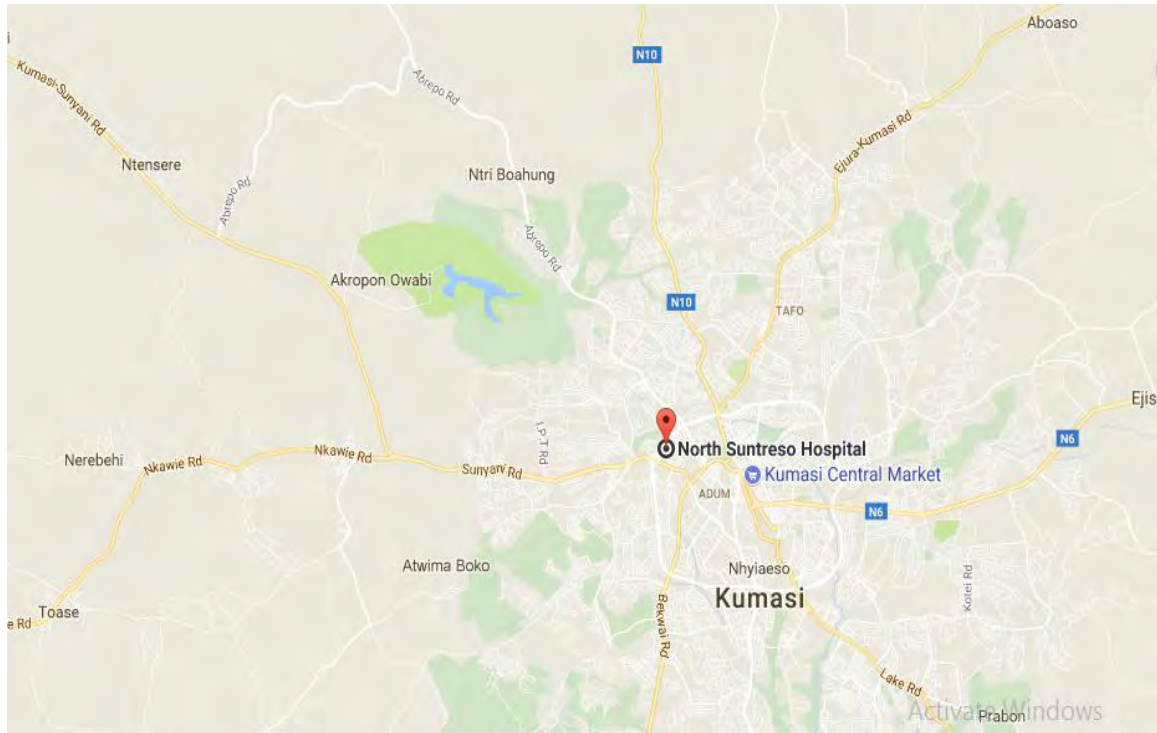


Fig. 3.1 Map showing location of Suntreso Government Hospital in the Bantama sub-metro.

3.3 Study population

The population comprised all caregivers of mental ill patients on admission or seeking health services at the Suntreso Government Hospital.

3.3.1 Inclusion criteria

- All caregivers, 18 years of age and above of mental ill patients.
- Guardians who were either or not related to the patient yet accompanied the patients to the health facility three times or more for reviews.
- Caregivers who had been looking after the patients in the last six months from the time the study was conducted.

3.3.2 Exclusion criteria

- All caregivers, below the age of 18 years of mental ill patients.
- Guardians who were not related to the caregiver and who rarely accompanied the caregiver to the health facility
- Caregivers who had been looking after the caregiver less than six months from the time the study was conducted

3.4 Study variables

Table 3.1 variables measured for the study

Variables	Indicator	Scale of measurement
Dependent variable	Quality of health care	Categorical
Independent variable		
Demographic characteristics of patients	Age	Continuous
	Sex	Nominal
	Education level	Ordinal
	Marital status	Nominal
Institutional barriers	Mental health experts	Discrete
	Financial resources	Ordinal
	Hospital beds	Ordinal
	Sanitary conditions	Ordinal
	Recreational facilities	Nominal
Perception of quality of care (caretakers)	Waiting time	Discrete
	Attitude of caregivers	Ordinal
	Caregiver-patient relationship	Ordinal
	Interaction with caregivers	Ordinal
Caregivers characteristics	Age	Continuous
	Employment	Nominal
	Monthly income	Ordinal

3.5 Sample size determination

Using the Yamane (1967) equation

$$n = \frac{N}{1 + N(e)^2}$$

N = population (190). Average attendance of mental health patients to the facility

e = standard error (0.05)

Substituting, $n = \frac{190}{1 + 190(0.05 \cdot 0.05)} = 129$

This number was increased to 136 to make up for 5% non-response rate

3.6 Sampling procedure

Simple random sampling technique was employed to select participants for the study. This was done by obtaining the register of all the mental ill patients and selecting from the attendance register the folders of all mental ill patients who access health care services at the Mental Health Department of Suntreso Government Hospital. Folders of mental ill patients who had been on admission for the past twenty-four weeks (six months) and patients who come and go on daily/weekly basis for reviews was selected. A total of 190 mental ill patients obtained from the mental health department served as the sample frame. The selection of caretakers of mental ill patients from the database was done by generating 136 participants from a sample frame of 250 with the help of a random number generator. Caregivers of patients whose numbers were selected was then identified and subsequently interviewed. A period of four weeks [one month] was used to interview the respondents via questionnaire. Face-to-face administration of questionnaire was conducted for the selected guardians of mental ill patients from Monday to Friday within the hours of 7am to 4pm each day.

3.7 Data collection techniques

The researcher collected data on quality of care mental ill patients receive at the Department of Mental Health, Sunreso Government Hospital. This was made possible based on quantitative approach through the use of questionnaire. The questionnaire was structured in a way that it sought relevant information to address the specific objectives of the study. To administer the questionnaire, participants were given consent form (Appendix 1) to read and sign prior to answering the questionnaire. The questionnaire was divided into three sections to collect information as follows; Section A: Parents' Characteristics/Socio-demographic characteristics: Age, sex, educational level and marital status. Section B: Caregivers perception of quality of care: waiting time, attitude of caregivers, caregiver-caregivers relationship and interaction with caregivers and Section C: Institutional barriers: mental health experts, financial resources, hospital beds, sanitary conditions and recreational facilities of the hospital. Each questionnaire was administered using within 30-40 minutes at the Sunreso Government Hospital. The data collection lasted for three weeks; started on 8th June and ended on 22nd June, 2018. The completed questionnaire was analyzed using STATA 15.

3.8 Quality control

- Study materials was explained to participants prior to the administration of questionnaire.
- Research assistants were intensively trained to carry out survey accurately.
- Questionnaires was cross checked by principal researcher prior to the administration of the questionnaire.

3.9 Data processing and analysis

Data was coded, processed and analyzed with Stata 15. Frequency distribution of all relevant variables was done. Relevant means and standard deviations were computed. Tests of significance using Chi Square and logistics regression were conducted. Chi square test statistic was used to measure the association between caregivers' perception of quality of mental health care delivery. Multiple logistic regression analysis, employing both Crude Odds Ratio (COR) and Adjusted Odds Ratio (AOR) with 95% confidence interval (CI) was used to ascertain the association between the dependent variable (quality of care) defined as comprehensive health care delivery and caregivers' socio-demographic/economic factors on quality of care. Quality of care is defined as a person's evaluation of clinical care, effectiveness of clinical care and effectiveness of inter-personal care (Campbell, Roland & Buetow, 2000). A questionnaire containing seven questions spanning clinical care, effectiveness of clinical care and interpersonal relationship established between caregivers and health personnel was used. All negative questions were reversed and the response were broken down into a binary response with those agreeing scored (good) one (1) and those who disagreed (poor) scored zero (0). For each section of caregivers' perception on quality of care, a composite mean score of 0.5 and below were categorized as "poor" while a composite mean score above 0.5 to 1 is categorized as "good". Proportions was used to measure the challenges that confront quality of mental health care delivery.

3.10 Pretesting

Pretesting of data collections tool (questionnaire) was done at Komfo Anokye Hospital with 10 participants to validate survey tools. The rationale is to ensure that the tool is clearly worded and bereft of major prejudices which seeks the type of information intended. It was also carried out with the aim of eliminating irrelevant questions so as to make it reliable.

3.11 Ethical consideration

3.11.1 Permission from study site

Introductory letter was obtained from the Department of Health Policy, Planning and Management (HPPM) of the School of Public Health (SPH) to Suntreso Government Hospital and was introduced to the head of the facility for permission to use the facility prior to the study.

3.11.2 Ethical clearance

The proposal was then be submitted to the Ghana Health Services (GHS) Ethical Review Committee for approval (GHS-ERC: 071/01/18)

3.11.3 Description of study participants

Participation in this study was entirely voluntary and participants had the option not to participate or to discontinue their participation without any adverse consequence. Participants were given sufficient information about the study to enable them decide whether to take part or not.

3.11.4 Informed consent

Written informed consent forms was given to participants to sign. All informed consent form was written in English. However, consents form was read out to caregivers who could not read and write to obtain their consent by thumb printing to participate in the study.

3.11.5 Privacy/Confidentiality

Participants were assured of the fact that this work is purposely academic and as such information they provide was protected with strict confidentiality. Participants were assured of

anonymity by not asking for their names and that no harm was intended. The study did not enquire any major cost for participants except the participants' time that was spent in answering the questionnaire. Participants were at liberty to withdraw from the study at will.

3.11.6 Potential risk and benefits

No risk or discomfort concerning participation in this research was anticipated apart from the time that was spent on answering the questionnaire. No direct benefit to participant, however the outcome of this study can be used to inform policy on quality of care for mental ill caregivers.

3.11.7 Data storage

The answered questionnaire was coded and entered onto Microsoft excel. The file sheet was uploaded onto a password protected Google drive account. The hard copies of the questionnaire was placed in sealed envelope and placed in locker with a key. This will be discarded after two years.

3.11.8 Conflict of interest

There was no conflict of interest.

CHAPTER FOUR

RESULTS

4.1 Description of study participants

A total of one hundred and thirty six (136) participants agreed to partake in the study. The participants' demographic characteristics are presented in Table 4.1. Majority of the participants were females, 91.91% (125/136); aged 31-37 years, 29.41% (40/136), have secondary education, 86.03% (117/136), are married, 75.0% (102/136) and are christians, 85.29% (116/136).

4.1 Table: Demographic characteristics of caregivers, Suntreso (n=136)

	Frequency	Percentage
Age (years)		
24-30	18	13.24
31-37	40	29.41
38-44	37	27.21
45-51	21	15.44
52-59	20	14.71
Educational level		
JHS	8	5.88
SHS/Voc/Tech	117	86.03
Tertiary	11	8.09
Marital status		
Single	26	19.12
Married	102	75.0
Divorced	8	5.88
Gender		
Male	11	8.09
Female	125	91.91
Religion		
Christian	116	85.29
Muslim	16	11.76
Traditionalist	4	2.94

JHS, Junior high school; SHS, Senior high school; Voc, Vocational; Tech, Technical

4.2 Perception of care among caregivers and quality of care

The relationship between caregivers' perception of care and quality of care delivery at Suntreso hospital is shown in Table 4.2. Largely, none of the perception of care variables correlates with quality of care delivery for mental health caregivers in the hospital. Thus, there was no significant association between perception of care variable and quality of care delivery ($p>0.05$).

Details showed that health professionals do not care much for the caregivers they treat 51.47% (35/136) though health professionals have in-depth knowledge on these caregivers condition 50.0% (34/136). Also, there was no association between health professionals satisfying needs of caregivers quality of care delivery ($\chi^2=1.8840$; $p=0.170$). There was no such association between making decisions on caregivers care and quality of care delivery ($\chi^2 =4.2343$; $p=0.516$).

No statistical significance was observed when struggling for free support and care and quality of care delivery was compared ($\chi^2 =0.1193$; $p=0.730$). No such relationship was observed between good safety of care and quality of care delivery ($\chi^2 =0.2661$; $p=0.606$).

Table 4.2 Bivariate analysis on association between perception of care and quality of care for mental health caregivers at Suntreso Government Hospital

Variables	N (%)	Quality of care		χ^2	p-value
		Poor	Good		
Good care by health professionals (HP)				0.4710	0.493
Yes	66 (48.53)	35 (51.47)	31 (45.59)		
No	70 (51.47)	33 (48.53)	37 (54.41)		
Good knowledge on mental health by health professionals				0.2652	0.607
Yes	65 (47.79)	31 (45.59)	34 (50.0)		
No	71 (52.21)	37 (54.41)	34 (50.0)		
Health professionals satisfy needs of caregivers				1.8840	0.170
Yes	66 (48.53)	37 (54.41)	29 (42.65)		
No	70 (51.47)	31 (45.59)	39 (57.35)		
Involved in decision making on caregivers social care				1.4712	0.225
Yes	104 (76.47)	55 (80.88)	49 (72.06)		
No	32 (23.53)	13 (19.12)	19 (27.94)		
Struggle for care and support for caregiver				0.1193	0.730
Yes	76 (55.88)	39 (57.35)	37 (54.41)		
No	60 (44.06)	29 (42.65)	31 (45.59)		
Assistance from HP for my caregiver to partake in leisure activities				0.1181	0.731
Yes	72 (52.94)	35 (51.47)	37 (54.41)		
No	64 (47.06)	33 (48.53)	31 (45.59)		
Good safety of care provision to caregiver				0.2661	0.606
Yes	73 (53.68)	35 (51.47)	38 (55.88)		
No	63 (46.32)	33 (48.53)	30 (44.12)		

Good attitude of nurses				0.000	1.000
Yes	92 (67.65)	46 (67.65)	46 (67.65)		
No	44 (32.35)	22 (32.35)	22 (32.35)		
Wait for long hours to see my caregiver				1.8889	0.169
Yes	72 (52.94)	40 (58.82)	32 (47.06)		
No	64 (47.06)	28 (41.18)	36 (52.94)		

4.3 Caregivers characteristics and quality of care

Details of the association between caregivers' characteristics and outcome of interest (quality of care delivery) at Suntreso hospital is shown in Table 4.3.

Quality of care is defined as a person's evaluation of clinical care, effectiveness of clinical care and effectiveness of inter-personal care (Campbell, Roland & Buetow, 2000). A questionnaire containing seven questions spanning clinical care, effectiveness of clinical care and interpersonal relationship established between caregivers and health personnel was used. All negative questions were reversed and the response were broken down into a binary response with those agreeing scored (good) one (1) and those who disagreed (poor) scored zero (0). For each section of caregivers' perception on quality of care, a composite mean score of 0.5 and below were categorized as "poor" while a composite mean score above 0.5 to 1 is categorized as "good".

Caregivers who earned more than 1000 GHS on monthly basis were 4.82 times more likely to perceive the quality of service as good compared to caregivers who earned 600-1000 GHS. Additionally, Muslims were 0.11 times higher to be satisfied with quality of care provided to mentally ill patients related to them.

However, adjusting for religion and monthly income, there was no significant association between caregivers' characteristics and outcome of interest (quality of care)

Table 4.3 Logistic regression: strength of association between caregivers' characteristics and quality of care for mental health caregivers at Suntreso Government Hospital

Characteristics	Quality of care			
	COR (95%CI)	P-value	AOR (95%CI)	P-value
Age (years)				
24-30	ref		ref	
31-37	0.42 (0.13, 1.35)	0.144	0.37 (0.09, 1.44)	0.150
38-44	0.53 (0.16, 1.70)	0.285	0.47 (0.13, 1.81)	0.271
45-51	0.29 (0.07, 1.23)	0.094	0.23 (0.05, 1.17)	0.076
52-59	0.42 (0.11, 1.65)	0.212	0.46 (0.10, 2.19)	0.328
Educational level				
JHS	ref		ref	
SHS/Voc/Tech	--		--	
Tertiary	0.22 (0.03, 1.75)	0.151	0.28 (0.23, 3.48)	0.323
Marital status				
Single	ref		ref	
Married	0.84 (0.32, 2.21)	0.730	0.85 (0.25, 2.86)	0.787
Divorced	--		--	--
Gender				
Male	ref		ref	
Female	0.42 (0.52, 34.03)		3.46 (0.36, 33.38)	0.283
Religion				
Christian	ref		ref	
Muslim	0.15 (0.19, 1.16)	0.070	0.11 (0.01, 1.04)	0.005
Traditionalist	0.74 (0.07, 7.37)	0.798	0.72 (0.63, 8.20)	0.791
Monthly income (GHS)				
100-500	ref		ref	
600-1000	2.44 (1.01, 5.90)	0.048	2.57 (1.00-6.64)	0.050
>1000	5.11 (1.52, 17.19)	0.008	4.82 (1.26, 18.37)	0.021

COR, Crude odds ratio; CI, Confidence interval; AOR, Adjusted odds ratio; Ref, Reference indicator

4.4 Barriers to quality health care

Details of barriers to quality health care is presented in Table 4.4. The unavailability of prescribed drugs could contribute to poor quality of care for mental health caregivers 77.21% (105/136). The lack of recreational facilities and activities hamper quality of care delivery for mental health caregivers 83.82% (114/136).

The limited number of mental health specialized doctors threatens quality of care delivery at the hospital 77.21% (105/136). A great proportion of caregivers 79.41% (108/136) agreed that limited number of hospital beds for admittance hampers quality of care for caregivers. Almost all the caregivers 66.18% (90/136) indicated that the sanitary condition of the hospital, especially the wards can hamper quality of care delivery.

Concerns of discrimination and stigmatization was cited as a challenge that affect the quality of care their patients received by caregivers. The results revealed that: they are disrespected because of their patients' condition 66.18% (90/136); separation of the mental health department smack of an attempt to treat their patients poorly 66.18% (90/136); poor attitude of health professionals towards mentally ill patients 75.74% (103/136).

Table 4.4 Challenges confronting quality health care delivery for mental health caregivers at Suntreso government hospital

	N (%)
Availability of prescribed drugs for caregivers	
Yes	31 (22.79)
No	105 (77.21)
Lack of recreational facilities	
Yes	114 (83.82)
No	22 (16.18)
Lack of mental health doctors/experts	
Yes	105 (77.21)
No	31 (22.79)
Limited number of hospital beds	
Yes	108 (79.41)
No	28 (20.59)
Poor sanitary condition in wards	
Yes	90 (66.18)
No	46 (33.82)
Discriminated against by health personnel because of my patient's condition	
Yes	45 (33.09)
No	91 (66.91)
Health personnel have disrespected me on several occasions	
Yes	46 (33.82)
No	90 (66.18)
Angry with the way the hospital have separated mental health patients	
Yes	90 (66.18)
No	46 (33.82)
Shocked by how health personnel and other people react to mental health patients	
Yes	103 (75.74)
No	33 (24.26)
Avoided and insulted because of my patient's mental health problems	
Yes	53 (38.97)
No	83 (61.03)

CHAPTER FIVE

DISCUSSION

5.1 Introduction

The aim of the study is to assess the quality of care mental ill patients receive at Suntreso Government Hospital. It had specific objectives to evaluate caregivers' perception on the quality of care mental ill patients received at the hospital, it also examined how caregivers characteristics affects quality of care for mental ill patients at the hospital and to describe the challenges that confront quality of care mental ill patients receive at the hospital.

5.2 Caregivers perception on quality of care

Details showed that health professionals do not care much for patients they treat though they have in-depth knowledge on patients' condition. There were more cases on daily basis compared to the number of specialist and or experts available to treat such cases at the hospital. The strain on mental health practitioners based on the number of cases they attended to on daily basis affects the outcome of care they assign to patients. Ideally, the number of patients to doctor ratio should not be too wide so as for a doctor to thoroughly treat and/or counsel a patient to know the full extent of their conditions. In a country where there is a dearth of mental health specialist, spending so much time on a patient could be detrimental to the survival of other patients. That is, spending much time on a patient could affect the other patients. Thus, the required attention are not meted to patients. It is not surprising that caregivers to mental ill patients at the hospital are not satisfied with the quality of care their patients received.

Also, there was no association between health professionals satisfying needs of patients. The needs of mental caregivers requires 'quality' time, a resource these health professionals do not

have because of the number of patients they have to see to on daily basis. Sometimes, a patient require a listening ear to 'pour' out his fears and concerns to achieve some level of sanity. There are other times patients require being waved at, smiled at and played with to become well. These are scarce resources, mental health professionals (nurses and doctors) at the hospital do not have at their disposal. They treat these patients based on their medical records and sometimes based on the narrative of a caregiver. No special day is assigned for counselling as the daily admissions continue to increase. Caregivers complained that the state of their patients' condition has not changed since they were admitted. It is thus, not surprising to stance of caregivers in terms of the quality of care their patients received.

There was no such association between making decisions on patients care and quality of care delivery. It is near impossible to alter the way health systems are managed in the country. Even when caregivers make decisions on how their patients should be treated and or handled, the available resource has the final say, thus, their decisions has little influence on care being provided. There are instances caregivers know the genesis of their patients condition. They do not have the required resources to provide for such needs. They provide health professionals with these information, hoping that their patients/relative/child (ren) recovers at a fast rate. These advices are thrown out of the window owing to unavailable resources and personnel. Patients are mostly met in the same state as they were admitted. This create a lot of dissatisfaction among caregivers who have given the 'remedy' and resources to treat their patients.

Again, caregivers had to struggle for their caregivers to receive free support and care. This is attributable to the number of cases recorded on daily basis and the available resource. It

becomes obvious for caregivers to force for their caregivers to be treated fairly. It is thus not surprising that caregivers do not feel safe about the quality of care provided for their caregivers.

By implication, perception of care mental health caregivers receive was poor. This is consistent with findings from Hall (2013), who found that lack of information on waiting times, poor interaction with caregivers and not sending appointment notices in adequate time before examination were more likely to have a perceived low quality of care. The findings further agreed with Horvitz-Lennon et al., (2014) who found that conditions for quality of care for individuals with mental disorder are clearly poor and this has been so for some time.

5.3 Caregivers characteristics on quality of care

Caregivers' age was not associated with quality of care delivery at Suntreso hospital. Delivering quality care of service to patients was not age bound. This means that a caregiver need not to be older to make a distinction between good and poor quality service delivery. This disagrees with a study, which found that older caregivers regard quality of care higher than younger caregivers (Kvist et al., 2013). On the contrary, a nation-wide study, showed that caregivers characteristics such as age, gender, and education level has low influence on satisfaction (Shou-Hisa, Ming-Chin & Tung-uang 2003).

Religious affiliation was associated with quality of care delivery. This could be attributed to the one's insight on health delivery. That is, some religion frown on accessing 'medical' care in its entirety and this could affect an individual's disposition on health care delivery and vice versa. The trend observed with caregivers religion could be true as most of the respondents

were christians. With the current Charismatic movement which preaches ‘unshakeable’ faith and heavenly healing directions, it is unsurprising to note that caregivers who are believers in the new Christian faith movement do not regard the quality of care their relatives receive.

Furthermore, caregiver’s monthly income was associated with quality of care. This means that childbearing comes with a lot of pain and emotion, as such caregivers will give everything to secure the ‘sanity’ of their children. They will pay any amount of money to ensure their affected child (ren) have access to the best health care delivery. By implication, the results mean that being financially ‘sound’ provides access to receiving quality health care services. This agree with studies which revealed a correlation between mental treatment and a better economic outcome (Lund *et al.*, 2011). In addition, a firm relationship was discovered to exist between the percentage of people with mental illness and countries with unequal income (Pickett & Wilkinson 2010).

5.3 Challenges confronting quality of care at Suntreso Government Hospital

The unavailability of prescribed drugs can contribute to poor quality of care for mental health patients. The lack of prescribed medication for patients can be attributed to the poor procurement, auditing and transparency in the management of the facility. Allowing everyone to roll as a boss with being accountable to anyone contributes to drugs shortages and theft and this situation affects the care meted out to patients.

The lack of recreational facilities and activities can hamper quality of care delivery for mental health patients. A healthy mind needs a healthy environment. Creating an avenue for patients to exhibit their talents when they are in the mood is key to quality care, unlike confining them to their beds at all times. The lack of such facilities can be attributed to mismanagement and poor maintenance culture.

The limited number of mental health specialized doctors threatens quality of care delivery at the hospital. In an ideal situation, a doctor should attend to not more than five patients so as to provide them with the best care. However, the limited number of specialist in the area of mental health can be attributed to low financial gains in the field. The scarcity of such doctors exposes patients to poor quality of care as a doctor has to attend to several other patients.

Limited number of hospital beds for admittance hampers quality of care for patients. This can be attributed to the increasing cases of the condition on daily basis. It can also be as a result of poor maintenance culture in the hospital. This results in patients being discharge before full recovery to make way for another patient. This leads to relapse and readmission.

Not discriminating against mentally ill patients by health professionals correlates with quality of care delivery for mental health patients in the hospital. This is attributable to the fact patients feel a sense of belonging. This relaxes their nerves and induces them to respond to treatment. Also, showing respect to caregivers and mental ill patients has significant association with quality of care delivery. But for one's condition, anything is achievable.

Affording patients the respect they need makes them human and this hastens their treatment process. Though most participants were not satisfied with the hospital separating mental patients from main stream health care seekers, this does not affect quality of care delivery. Segregation has several connotations and these connotations have adverse effect on health outcomes especially. Talking to someone is as therapeutic as seeing someone.

Separating mental health patients put a strain on their psychological make-up and this affects the kind of care they receive. Similarly, most of the participants expressed shocked at how health professionals and other people react to mental health patients. Inasmuch as these patients can sometimes veer from normalcy, it is imperative to treat them right. The results corroborate Schröder (2006) who discovered that patients' views of quality of care centres on help received to minimize stigmatization and being seen as every other person. Schröder (2006) further explained that patients had a good disposition towards the idea of good quality of care, which they measured by the staff respecting the dignity of the patient, the patient feeling secured in the ability of the staff to care for them, the patient participating in such care, the care being performed in a supportive environment and the patient ultimately recovering. The study also corroborates that individuals with mental disorder are mostly marginalized and discriminated and this is contrary to their enjoyment of the right to health (Hunt, 2005; WHO 2001). High level of stigmatization is linked to lower usage of mental health services (Kim et al., 2010). The findings further agree with a study, which found that insufficient availability of doctors create an ethical and legal dilemma and placed the patient's safety at risk (Eygelaar & Stellenberg, 2012). The finding also corroborated that the distribution and allocation of mental health services, poor health education, the long duration of treatment, and fear of stigma are barriers to the utilization of mental health services (Abdelgadir, 2012).

5.4 Study limitations

Given that the present study was undertaken in one hospital which is not a full flagged psychiatric hospital, caregivers perception of care could vary from that of other teaching hospitals, preventing the generality of the findings results.

Also, the influence of the interviewer on respondents' answers was a limitation in that respondents felt 'induced' to provide an answer at all cost.

Another limitation is that the study did not compare the relationship that exist between caregivers and patients suffering from the condition according to disease severity and treatment options.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

Caregivers studied in Suntreso Government hospital showed poor perception on the quality of care the hospital provides for their patients (relatives). This exposes inhumane treatment meted out mentally ill patients seeking treatment at the facility. Also, caregivers age, educational attainment, marital status and employment status did not influenced their perception on quality of care delivered to their patients. Caregivers monthly income and religious affiliation influenced their perception on the quality of care provided for their patients. There are variations in the challenges/barrier that confronts quality of care at the facility. Among these barriers are unavailability of drugs, lack of mental health specialists and lack of hospital beds.

6.2 Recommendations

The Ghana Health Service together with the Ministry of Health should collaborate with other stake holders, such as the media, to gather information on the interaction between caregivers and staff at the hospitals. The importance of this is to show instances that results in poor attitude either from caregivers or health professionals or vice versa.

The management of Suntreso Hospital should provide periodic updates for caregivers to diffuse any misgivings they might hold against the hospital. Nurses who exhibit good behaviour towards caregivers/caregivers should be rewarded to motivate them.

Also, a complaint unit could be formed to address grievances and complaints of clients and relatives who visit the facility.

Management of the hospital should ensure that drugs and other essential resources are procured in the right quantities to eschew shortages. Records of attendance should be used as a measure to commence an expansion project to accommodate every caregiver. Further studies can be undertaken to examine health providers perception of care for mental health caregivers.

REFERENCES

- Abdelgadir E. (2012). Exploring barriers to utilization of mental health services at the policy and facility level in Khartoum Sudan. Thesis (master's)-University of Washington
- Agyemang, G. A. (2013). Nurse- patient relationship in health care delivery in Koforidua. *Journal of Biology, Agriculture and healthcare*, 3 (3), 100-132.
- Ahmed, K.E.K, & Tarek, K. (2012). Mental health services in the Arab world. *World Psychiatry*. 11 (1): 52.
- Aiken, L. H., Clarke, S. P., & Sloane, D. M. (2015). Hospital staffing, organization, and quality of care: Cross-national findings. *Nursing Outlook*, 50(5), 187–194. doi:10.1067/mno.2002.126696
- Akpalu, B., Doku, V., Lund, C., Ofori-Atta, A., Osei, A., Ae-Ngibise, K., ... Flisher, A. J. (2010). Scaling up community-based services and improving quality of care in the state psychiatric hospitals: the way forward for Ghana : original article. *African Journal of Psychiatry*. 13(2), 109-15.
- Aldana, J. M., Piechulek, H., & Al-Sabir, A. (2001). Client satisfaction and quality of health care in rural Bangladesh. *Bulletin of the World Health Organization*, 79: 512 – 517
- Andaleeb, S. S. (2001). Service quality perceptions and patient satisfaction: a study of hospitals in a developing country. *Social science & medicine*, 52(9), 1359-1370.
- Andaleeb, S. S. (2005). Service quality perceptions and patient satisfaction: a study of hospitals in a developing country. *Social science & medicine*, 52(9), 1359-1370.
- Avis, M., & Band, M. (1995). Satisfying solution? A review of some unresolved issues in the measurement of caregiver satisfaction. *Journal of Advanced Nursing* 22 (6), 316-322
- Awadalla, A. W., Ohaeri, J. U., Salih, A. A., & Tawfiq, A. M. (2005). Subjective quality of life of family caregivers of community living Sudanese psychiatric patients. *Social psychiatry and psychiatric epidemiology*, 40(9), 755-763.
- Awenva A.D, Read U.M, Ofori-Attah A.L, Doku V.C.K, Akpalu B, Osei A.O. (2010). From mental health policy development in Ghana to implementation: what are the barriers? *Afr J Psychiatry*; 13(3):184–91.
- Ayimbillah Atinga, R., AbekahNkrumah, G., & Ameyaw Domfeh, K. (2011). Managing healthcare quality in Ghana: A necessity of patient satisfaction. *International Journal of Health Care Quality Assurance*, 24(7), 548-563.

- Ayuso-Mateos, J. L., Gutierrez-Recacha, P., Haro, J. M., & Chisholm, D. (2006). Estimating the prevalence of schizophrenia in Spain using a disease model. *Schizophr Res*, 86(1-3), 194-201. doi: 10.1016/j.schres.2006.06.003
- Baltussen, R., Yé, Y., Haddad, S., & Sauerborn, R. S. (2002). Perceived quality of care of primary health care services in Burkina Faso. *Health Policy and Planning*, 17 (1), 42–48.
- Bishop T.F, Press M.J, Keyhani S, & Pincus H.A. (2014). Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA Psychiatry*; 71(2):176-81. doi: 10.1001/jamapsychiatry.2013.2862
- Blomberg, F., Brulin, C., Andertun, R., & Rydh, A. (2010). Patients' Perception of Quality of Care in a Radiology Department: A Medical-Physical Approach. *Journal of Radiology Nursing*, 29(1), 10-17.
- Blumenthal, D. (1996). Quality of care -what is it? *New England Journal of Medicine*, 335(12), 891–894.
- Bollini, P., Pampallona, S., Tibaldi, G., Bianco, M., Nieddu, S., & Munizza, C. (2008). Structural and organizational determinants of quality of care in patients with schizophrenia in Italy. *Journal of Nervous and Mental Disease*, 196(12), 923–926.
- Bresnick, J. (2013). Nurses need to interact with patients while using laptops, EHRs, 13 (1), 45-60.
- Brook, R. H., McGlynn, E. A., & Shekelle, P. G. (2000). Defining and measuring quality of care: a perspective from US researchers. *International Journal for Quality in Health Care*, 12(4), 281–295.
- Bruwer B, Sorsdahl K, Harrison J, Stein DJ, Williams D, Seedat S. (2011). Barriers to mental health care and predictors of treatment dropout in the South African Stress and Health Study. *Psychiatr Serv*; 62 (7):774–81. 9.
- Burke, A., Peper, E., Burrows, K. & Kline, B. (2004). Developing the complementary and alternative medicine education infrastructure: Baccalaureate programs in the United States. *The Journal of alternative and complementary medicine*, 10 (6), 1115 –1121.
- Can, P. R., O'Connor, P. M., Dermott, K. & Hood, J. (2013). How death anxiety impacts nurses caring for patients at the end. A review literature. *The Open Nursing Journal*, (7), 14-21.
- Campbell, S. M., Roland, M. O., & Buetow, S. A. (2000). Defining quality of care. *Social Science & Medicine*, 51(11), 1611–1625.

- Chakraborty, R., & Majumdar, A. (2011). Measuring consumer satisfaction in health care sector: The applicability of servqual. *International Refereed Research Journal*, 2(4), 149-160.
- Chien, W. T., & Wong, K.-F. (2007). A family psychoeducation group program for Chinese people with schizophrenia in Hong Kong. *Psychiatric Services*, 58(7), 1003–1006.
- Clark, E., Squire, S., Heyme, A., Mickel, M. & Petrie, E. (2009). Clinical handover: critical communication *The PACT project, MJA*, 190 (11), 1-9.
- Cooperberg, M. R., Birkmeyer, J. D., & Litwin, M. S. (2009). Defining high quality health care. *Urologic Oncology: Seminars and Original Investigations*, 27(4), 411–416. doi:<http://dx.doi.org/10.1016/j.urolonc.2009.01.015>
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist* 59/7, pp. 614–625
- Costa, C. S., Bandeira, M., Cavalcanti, R. L., & Scalón, J. D. (2011). Perceptions by patients and families towards treatment outcomes in mental health services. *Cad Saude Publica*, 27(5), 995-1007.
- Coughlin, C. (2012). An ethnographic study of main events during hospitalization: perceptions of nurses and patients. *Journal of Clinical Nursing*, 8 (2), 99-109
- Culyer, A. (2004). Involving stakeholders in healthcare decisions--the experience of the National Institute for Health and Clinical Excellence (NICE) in England and Wales. *Healthcare Quarterly* (Toronto, Ont.), 8(3), 56-60.
- D'Ambruso, L., Abbey, M., & Hussein, J. (2005). Please understand when I cry out in pain: Women's accounts of maternity services during labour and delivery in Ghana. *BMC Public Health*, 5(1), 140.
- Doku, V. C. K., Wusu-Takyi, A., & Awakame, J. (2012). Implementing the mental health Act in Ghana: any challenges ahead? *Ghana Medical Journal*, 46(4), 241.
- Donabedian, A. (1966). Evaluating the quality of medical care. *The Milbank Memorial Fund Quarterly*, 44(3), 166–206
- Donabedian, A. (1988). The quality of care: How can it be assessed? *Jama*, 260(12), 1743–1748.
- Druss, B. G. (2007). Improving medical care for persons with serious mental illness: challenges and solutions. *J Clin Psychiatry*, 68(41), 40–44.

- Fisher W.H, Roy-Bujnowski K, Grudzinskas A.J, (2011). Patterns and prevalence of arrest in a statewide cohort of mental health care consumers. *Psychiatric Services*; 57(1): 1623–1628.
- Gable L. & Gostin, L. (2009). Mental health as a human right in A. Clapham, M. Robinson, C. Mahon, et al. (eds), *Realizing the Right to Health* (Zurich, Switzerland: Rüffer & Rub), 220-250.
- Gilbert, F. W., Lumpkin, J. R., & Dant, R. P. (1992). Adaptation and customer expectations of health care options. *Journal of Health Care Marketing*, 12(3), 46-55.
- Glasberg, A. L. (2007). Stress of conscience and burnout in health care. The danger of deadening in one's conscience. *Medical thesis, Umea University, Umea, Sweden*.
- Goodhead, A., & McDonald, J. (2007). Informal caregivers literature review. A report prepared for the National Health Committee. Wellington: Health Services Centre, Victoria University of Wellington, United States.
- Graham, W., Wagaarachchi, P., Penney, G., McCaw-Binns, A., Yeboah Antwi, K., & Hall, M. H. (2000). Criteria for clinical audit of the quality of hospital-based obstetric care in developing countries. *Bulletin of the World Health Organization*, 78(5), 614–620.
- Gurney, C. (2010). Nursing rounds improve patient outcomes. Research news you can use: begin your practice on evidence. Accessed on 24/11/2017 from www.nynsa.org/publications/report/research.htm.
- Haddad, S., & Fournier, P. (1995). Quality, cost and utilization of health services in developing countries. A longitudinal study in Zaïre. *Social Science & Medicine*, 40(6), 743–753.
- Hall, R. (2013). *Patient flow: Reducing delay in healthcare delivery* (Vol. 206): Springer Science & Business Media. New York, 158(3), 169-178.
- Haugan, G. (2013). Nurse-patient interaction is a resource of hope, meaning in life and self-transcendence in nursing home patients. *Scandinavian Journal of Caring Science*, 2(13), 111-145
- Hamsley, B., Balaidin, K & Worrall, L. (2012). Nursing the patient with complex communication needs: time as a barrier and a facilitator to successful communication in hospital. *Journal of Advance nursing*, 68 (1) 116 -126.
- Hanrahan, N. P., & Aiken, L. H. (2008). Psychiatric nurse reports on the quality of psychiatric care in general hospitals. *Quality Management in Health Care*, 17(3), 210–217. doi:10.1097/01.QMH.0000326725.55460.af

- Hanzawa, S., Tanaka, G., Inadomi, H., Urata, M., & Ohta, Y. (2008). Burden and coping strategies in mothers of patients with schizophrenia in Japan. *Psychiatry and Clinical Neurosciences*, 62(3), 256–263.
- Heisler, Michele, I. Cole, David Weir, E.A. Kerr, and R.A. Hayward. (2007). "Does physician communication influence older patients' diabetes self-management and glycemic control? Results from the Health and Retirement Study (HRS)." *Journals of Gerontology Series a-Biological Sciences and Medical Sciences*, 62(12): 1435-1442.
- Hermanns, M., & Mastel-Smith, B. (2012). Caregiving: a qualitative concept analysis. *The Qualitative Report*, 17(38), 1–18.
- Hermann, R. C., Finnerty, M., Provost, S., Palmer, R. H., Chan, J., Lagodmos, G., ... Myrhol, B. J. (2002). Process measures for the assessment and improvement of quality of care for schizophrenia. *Schizophrenia Bulletin*, 28(1), 95.
- Horvitz-Lennon, M., Donohue, J. M., Domino, M. E., & Normand, S.-L. T. (2009). Improving quality and diffusing best practices: The case of schizophrenia. *Health Affairs*, 28(3), 701–712.
- Horvitz-Lennon, M., Volya, R., Donohue, J. M., Lave, J. R., Stein, B. D., & Normand, S.-L. T. (2014). Disparities in quality of care among publicly insured adults with schizophrenia in four large U.S. States, 2002–2008. *Health Services Research*, 49(4), 1121–1144.
- Hunt, P. (2005). UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report to the Commission on Human Rights (Main focus: Mental disability and the right to health), UN Doc. No. E/CN.4/2005/51. 18-19.
- James, D. J., & Glaze, E. (2006). Mental health problems of prison and jail inmates. Accessed on 25th June, 2018 from <http://bjs.ojp/usdoj.gov/content/pub/pdf/mhppji.pdf>
- José M. Q. Nerea, G. Amaia, B. Felipe, A. Antonio, E. Cristóbal, E. José, A. S. Emilio, S. & Andrew, T. (2006). Predictors of caregiver satisfaction with hospital health care. *Health Services Research*, 6, (102): 29-63
- Kim P.Y, Thomas J.L, Wilk J.E, Castro C.A, Hoge C.W. (2010). Stigma, barriers to care, and use of mental health services among active duty and National Guard soldiers after combat. *Psychiatr Serv*. 61 (6)582-588.

- Kvist T, Mäntynen R, Turunen H, Partanen P, Miettinen M, ...& Vehviläinen-Julkunen K (2013): How magnetic are Finnish hospitals measured by transformational leadership and empirical quality outcomes? *J Nurs Manag*, 21:152–164.
- Larrabee, J.H.B. & Lois, V. (2001). Defining caregiver perceived quality of nursing care. *Journal of Nursing Care Quality*, 16 (1), 34-60.
- Lim, J.R, Sullivan, P.S. Salazar, Laura S. A. C. & DiNenno, E. A. (2011). History of Arrest and Associated Factors among Men Who Have Sex with Men: *J Urban Health*; 88(4): 677–689
- Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, Das J. (2011). Poverty and mental disorders-breaking the cycle in low-income and middle-income countries. *Lancet*. 378 (9801), 1502-1514
- Janner, M. & Delaney, K. R. (2012). Safety issues on British mental health wards. *Journal of the American Psychiatric nurses association*, 3 (1), 89-121.
- Johansson, P., Oleni M., & Fridlund, B.(2002).Patient satisfaction with nursing care in the context of health care: a literature study. *Scandinavian Journal of Caring Science*, 16:337–344.
- Kreyenbuhl, J., Nossel, I. R., & Dixon, L. B. (2009). Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. *Schizophrenia Bulletin*, 35(4), 696–703.
- LA Public Health. (2010). *Informal caregiving: Implications for public health* (p. 6). Los Angeles, CA.
- Lasiter, S. (2013).The button: Initiating the patient – nurse interaction. *Clinical Nursing research*, 5 (2), 29-56. doi: 10.1177/1054773813479794x.
- Lehman, A. F. (1999). Quality of care in mental health: the case of schizophrenia. *Health Affairs*, 18(5), 52–65.
- Litaker, D., Mion, L. C., Planavsky, L., Kippes, C., Mehta, N., & Frolkis, J. (2003). Physician-nurse practitioner teams in chronic disease management: The impact on costs, clinical effectiveness, and patients' perception of care. *Journal of Interprofessional care*, 17(3), 223-237.
- McLaughlin, C. G. (2004). Delays in treatment for mental disorders and health insurance coverage. *Health Services Research*, 39(2), 221-224.

- McQuillan, P., Pilkington, S., Allan, A., Taylor, B., Short, A., Morgan, G., ... Smith, G. (1998). Confidential inquiry into quality of care before admission to intensive care. *BMJ*, *316*(7148), 1853–1858.
- Marek, A. (2003). The Missing Link: Public Policy for the Private Sector in Central and East. *SRHE International News*, *52*, 6-8.
- Mensah, K., Mackintosh, M. & Henry, L. (2013). The „Skills Drain“ of Health Professionals from the developing World: A Framework for Policy Formulation. London: Medact.
- Mental Health and Development (2012). Targeting People with mental health conditions as a vulnerable group. Mental Health Poverty Project
- Mental health (mh) GAP (2008). AcAon Programme. World Health Organization. Accessed on 30/10/2017 from [hVp77www.who.int7mentalWhealth7mhgap7mhGAPWnlWdecemberW2'11.pdf](http://www.who.int/mentalhealth/mhgap/mhGAPWnlWdecemberW2'11.pdf).
- Messias, E. L., Chen, C.-Y., & Eaton, W. W. (2007). Epidemiology of schizophrenia: review of findings and myths. *Psychiatric Clinics of North America*, *30*(3), 323–338.
- Ministry of Health (2009). National Health Policy: Promoting People's Health to Enhance. Accra-Ghana: Ministry of Health.
- Mitchell, P. H. (2008). Defining patient safety and quality care: An evidence-based handbook for nurses. *Agency for health care research and quality*, *20*(1), 22-30.
- Mwabu, G., Ainsworth, M., & Nyamete, A. (1993). Quality of medical care and choice of medical treatment in Kenya: An empirical analysis. *The Journal of Human Resources*, *28*(4), 838–862. doi:10.2307/146295
- Neville, K., Lake, K., Le Munyin, D., Paul, D. & Witmore, K. (2012). Nurses perception of patient rounding. *Journal of Nursing administration*, *42* (2), 83-88.
- Nguyen Thi P.L, Briançon S, Empereur F, & Guillemin F. (2002). Factors determining incaregiver satisfaction with care. *Soc Sci Med*; *54*(4):493-504.
- Nguyen, T. V., Bosset, J. F., Monnier, A., Fournier, J., Perrin, V., Baumann, C., . . . Mercier, M. (2011). Determinants of patient satisfaction in ambulatory oncology: A cross sectional study based on the OUT-PATSAT35 questionnaire. *BMC cancer*, *11*, 526 - 527.
- Nyonator, F., & Kutzin, J. (1999). Health for some? The effects of user fees in the Volta Region of Ghana. *Health Policy and Planning*, *14* (4), 329–341.

- O'Brien, A., Fahmy, R., & Singh, S. P. (2009). Disengagement from mental health services. *Social Psychiatry and Psychiatric Epidemiology*, 44(7), 558–568.
- Ofoedu, O. P. (2015). Caregivers' perceptions of quality of care for patients with schizophrenia at Pantang hospital, Accra. Masters dissertation, University of Ghana, Accra
- Ofori-Atta, A., & Ohene, S. (2015). Changing trends in mental health care and research in Ghana: . Sub-Saharan Publishers. Retrieved on 25/11/2017 from <https://books.google.com.gh/books?id=1x6-CQAAQBAJ>
- Oyvind A. B., Ingeborg, S., S., & Hilde, H., I. (2011). Overall caregiver satisfaction with hospitals: effects of caregiver-reported experiences and fulfillment of expectations, *British Medical Journal Quality Safety*, 3 (4): 88-100
- Otani K, Herrmann P.A, & Kurz R.S. (2011). Improving caregiver satisfaction in hospital care settings. *Health Serv Manage Res*; 24(4):163-169.
- Paasche-Orlow M, Roter D. (2003).The communication patterns of internal medicine and family practice physicians. *The Journal of the American Board of Family Practice*, 16(6):485–493.
- Patel E. (2009). The future of psychiatry in low- and middle-income countries. *Psychol Med*. 39 (11): 1759-1762
- Peplau, H. (1952). *Interpersonal Relations in nursing*. G. P. Putnam's Son, New York, USA
- Peprah, A. A., & Atarah, B. A. (2014). Assessing Patient's Satisfaction using SERVQUAL Model: A Case of Sunyani Regional Hospital, Ghana. *International Journal of Business and Social Research*, 4(2), 133-143.
- Pickett K.E, Wilkinson R.G. (2010). Inequality-an under acknowledge source of mental illness and distress. *Br J Psychiatry*. 197 (6) 426-428.
- PsychCentral. (2006). What Causes Schizophrenia? Accessed on 19/11/2014, from <http://psychcentral.com/lib/what-causes-schizophrenia/000715>
- Quinn, N. (2007). Beliefs and community responses to mental illness in Ghana: the experiences of family carers. *International Journal of Social Psychiatry*, 53(2), 175–188.
- Radtrek, K. (2013).Improving patient satisfaction with nursing communication using bedside shift report, *Clinical Nurse Speculation*, 27 (1):19 25.
- Rama M, & Kanagaluru S. K. (2011). A study on the satisfaction of caregivers with reference to hospital services. *International Journal of Business Economics & Management Research*, 1 (3): 97-105

- Rao D, Kekwaletswe TC, Hosek S, Martine J, Rodrigue F. (2007). Stigma and social barriers to medical on adherence with urban youth living with HIE. *AIDS Care*. 19 (1) 28-33.
- Reerink, I. H., & Sauerborn, R. (1996). Quality of Primary Health Care in Developing Countries: Recent Experiences and Future Directions. *International Journal for Quality in Health Care*, 8(2), 131–139.
- Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *The Lancet*, 370(9590), 878–889.
- Sen, A. (2002). Health: perception versus observation: self-reported morbidity has severe limitations and can be extremely misleading. *BMJ: British Medical Journal*, 324(7342), 860 end page.
- Schulz, R., & Sherwood, P. R. (2008). Physical and mental health effects of family caregiving. *The American Journal of Nursing*, 108(9 Suppl), 23–27.
- Schröder, A., Ahlström, G., & Larsson, B. W. (2006). Patients' perceptions of the concept of the quality of care in the psychiatric setting: a phenomenographic study. *Journal of Clinical Nursing*, 15(1), 93–102.
- Shattell, M. (2002). "Eventually it'll be over:" The dialectic between confinement and freedom in the phenomenal world of the hospitalized patient. In S. Thomas & H. Pollio (Eds.), *Listening to patients: A phenomenological approach to nursing research and practice* (pp. 214–236). New York: Springer.
- Sharma, T. (2003). Characterisation of cognitive impairment in schizophrenia. *The Lancet Neurology*, 2(1), 10-11.
- Shou-Hisa C, Ming-Chin Y, & Tung-uang C. (2003). Caregiver satisfaction with and recommendation of a hospital: effects of interpersonal and technical aspects of hospital care. *International Journal for Quality in Health Care*, 15 (4):345-355.
- Smith, M., & Segal, J. (2013). Schizophrenia: Signs, Types & Causes. *Journal of Psychiatric Research*. 47(5), 774 - 782.
- Thorsteinsson, L. (2002). The quality of nursing care as perceived by individuals with chronic illnesses: The magical touch of nursing. *Journal of Clinical Nursing*;11(1):32–40.

- Tonio S, Joerg K, & Joachim K. (2011). Determinants of caregiver satisfaction: a study among 39 hospitals in an in-caregiver setting in Germany. *International Journal for Quality in Health Care*; 23(5):503-509.
- Tunner, T., & Salzer, M. (2006). Consumer perspectives on quality of care in the treatment of schizophrenia. *Administration and Policy in Mental Health and Mental Health Services Research*, 33(6), 674–681.
- U.S. Department of Health and Human Services [USDHHS] (2001). *Mental health: Culture, race, and ethnicity: A supplement to Mental Health: A Report of the Surgeon General*. Washington, DC: Author; 2001.
- Waddington, C. J., & Enyimayew, K. A. (2009). A price to pay: The impact of user charges in Ashanti-Akim district, Ghana. *The International Journal of Health Planning and Management*, 4(1), 17–47. doi:10.1002/hpm.4740040104
- Waldrop, D. (2006). Caregiving systems at the end of life: How informal caregivers and formal providers collaborate. *Families in Society: The Journal of Contemporary Social Services*, 87(3), 427–437.
- Walsh, M. & Crumbie, A. (2007). *Watson's clinical nursing and related sciences*. (7th Ed.). Elsevier, Philadelphia, USA.
- Watson, J. (2001a). *Postmodern nursing and beyond*. Philadelphia: Churchill Livingstone.
- Ware, N. C., Tugenberg, T., & Dickey, B. (2004). Practitioner relationships and quality of care for low-income persons with serious mental illness. *Psychiatric Services*, 55(5), 555–559.
- Watson, J. (2005). *Caring Science as Sacred Science*. Philadelphia, PA: FA Davis Company; College of Nurses of Ontario. Therapeutic nurse-client relationship. Retrieved on 20/11/2017 from http://www.cno.org/docs/prac/41033_Therapeutic.pdf
- Westbrook, J., Duffield, C., Li, L. & Creswick, N. J. (2011). How much time do nurses have for patients? A longitudinal study quantifying hospital nurses' patterns of task time distribution and interactions with health professional, *BMC Health Research*, 11 (1):319-340.
- Williams D.R, Yu Y, Jackson J.S, & Anderson N.B. (1997). Racial differences in physical and mental health socio-economic status, stress and discrimination. *Journal of Health Psychology*, 2:335–351
- Williams, B. (1994). Patient satisfaction: A valid concept? *Social Science & Medicine*, 38(4), 509–516.

- Wood, F. G. (1991). The meaning of caregiving. *Rehabilitation Nursing*, 16(4), 195–198.
- World Health Organization [WHO] (2011). Mental health atlas Accessed on the 22/11/2017 from http://apps.who.int/iris/bitstream/10665/44697/1/9799241564359_eng.pdf.
- World Health Organization (2008). Healthcare quality measures-Statewide quality report. Geneva: World Health Organization.
- World Health Organization (2011). Primary healthcare: Now more than Ever. Geneva: World Health Organization.
- World Health Organisation (2004). Mental Health Atlas Geneva: World Health Organisation. Accessed 04/02/2018 from <http://apps.who.int/globalatlas/default.asp>.
- World Health Organisation (2002): World Health Report 2001. Mental Health: New Understanding, New Hope Geneva: World Health Organisation; 2001
- World Health Organization [WHO] (2001). The world health report on mental health: New understanding, new hope (Geneva: WHO). pp. 249–261
- Wysong, P & Driver, E. (2009). Patients' perceptions of nurses skills .*Journal of critical care nursing*, 29 (4), 23-41.
- Young, A., Klap, R., Sherbourne, C., & Wells, K. (2001). The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry*, 58(1), 55–61.
- Young, A., Sullivan, G., Burnam, M., & Brook, R. (1998). Measuring the quality of outpatient treatment for schizophrenia. *Archives of General Psychiatry*, 55(7), 611–617.
- Yusuf, A. J., Nuhu, F. T., & Akinbiyi, A. (2009). Caregiver burden among relatives of patients with schizophrenia in Katsina, Nigeria. *South African Journal of Psychiatry*, 15(2), 43-47.
- Zamanzadeh, V., Azimzadeh, R., Rahmani, A. & Valizadeh, L. (2010) .Oncology patients' and professional nurses' perceptions of important nurse caring behaviors

APPENDICES

Appendix I: Informed consent form

Principal Investigator: Joyce Nsiah, School of Public Health, University of Ghana, Legon.

Tel: 0544264337, email: joylove2312@yahoo.com

Introduction

This study sought to assess the quality of care mental ill caregivers receive at Suntreso Government Hospital.

Procedures

This involved obtaining the register of all the mental ill caregivers and selecting from the attendance register the folders of all caregivers who access health care services at the Mental Health Department of Suntreso Government Hospital. Folders of mental ill caregivers who had been on admission for the past twenty-four weeks (six months) and caregivers who come and go on daily/weekly basis for reviews were selected. A period of four weeks [one month] was used to interview the respondents via questionnaire. The questionnaire had separate sections for socio-demographic data, caregivers perception on quality of care and barriers to quality of care. This study is purely an academic work which forms part of my requirement for the award of a Master of Public Health degree.

Risks and Discomforts

There was not any potential risks to respondents whose formed part of the study. No risk or discomfort is foreseen concerning your participation in this research apart from your time that was spent in participating in answering the questionnaire. Sensitive information to be included in the study was presented as a group data so that individual records was not alluded to. Each questionnaire took 15-20 minutes on the average to complete.

Benefits and Reimbursement

There was no direct benefit to respondents whose information was used, but the findings will likely help find out more about cues to quality of care for mental ill caregivers. Participants were not provided any incentive to respond to the survey required for this research. It is hoped that results gathered is shared with policy makers, academia, and other stakeholders to improve quality of care for mental ill caregivers.

Confidentiality and Anonymity

To protect the identity of participants, the questionnaire did not include caregivers' name, rather this was substituted with assigned identification numbers. Information from the questionnaire was not be shared with other individuals outside the research team. In publishing, data will be reported as group data so that individual records will not be alluded to.

Participant consent form

I have been thoroughly briefed on the entire methodology and significance of the ongoing study which is being conducted by Joyce Nsiah. On my own free will, I hereby consent to be part of the study, based on my understanding of what the study entails.

I am doing this on condition that under no circumstance should my references be made to my actual identity to any other person(s) after providing all the information requested from me for this particular study as promised by the researcher.

Respondent signature..... Date

Witness' signature Date

Researcher signature Date

Who to Contact

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact the principal investigator Mrs. Joyce Nsiah (0544264337). This proposal will be reviewed and approved by the Ghana Health Service Ethical Review Committee, which is a committee whose task is to make sure that research participants are protected from harm. If you wish to find out more about the ERC, contact Hannah Frimpong (0243235225/0250704223)

Appendix II: Research questionnaire

<p>QUALITY OF MENTAL HEALTH CARE AT THE SUNTRESO GOVERNMENT HOSPITAL</p>
<p>PARTICIPANT CONSENT</p> <p>I am a student of the School of Public Health, University of Ghana. The administration of this questionnaire is to solicit your response on the above topic. All the information is strictly for academic purposes and will be highly treated with the greatest level of confidentiality.</p>

QID	QUESTIONS	Coding categories	Skip to	CODES
Section A: Socio-Demographic Characteristics of Respondents				
1	Age of respondentsyears		AGE
2	Educational level	No formal education..... 1 Primary..... 2 JHS.....3 SHS/Tech/Voc..... 4 Tertiary..... 5		EDU
3	Marital status	Single.....1 Married.....2 Divorced3 Widowed..... 4		MARITAL
4	Employment	Civil servant.....1 Nongovernmental employee....2 Self-employed.....3 Student.....4 Retired.....5 Unemployed.....6		EMPLOY
5	Gender	Male.....1 Female.....2		SEX
6	Religion	Christian.....1 Muslim.....2 Traditionalist.....3		REL

SECTION B: Perception of care			
7	Are the people who provide care (the professional staff) good at their jobs?	Yes1 No.....2	GOOD_CARE
8	Do the people who provide care know enough about the condition or disability?	Yes1 No.....2	EXPERTS_AVAILABLE
9	Do the people who provide care meet the caregiver's needs?	Yes.....1 No.....2	PAT_NEEDS
10	Are you involved in decisions about the caregiver's health and/or social care?	Yes.....1 No.....2	DECISION_INVOLVED
11	Do you have to fight for care and support your caregiver needs?	Yes.....1 No.....2	NEEDED_CARE
12	Does a lack of facilities at the hospital limit the care and support your caregiver get?	Yes.....1 No.....2	LACK_FACILITIES
13	Do your caregiver get help to take part in leisure activities?	Yes.....1 No.....2	RECREATION_FACILITY
14	Do your caregiver take part in social activities often?	Yes.....1 No.....2	SOCIAL_ACCEPTANCE
15	Do you feel safe about the care your caregiver get?	Yes.....1 No.....2	SAFE_CARE
16	Were the nurses nice and polite during registration?	Yes.....1 No.....2	ATT_NURSES
17	Did you have to wait too long in the waiting room for your visit?	Yes.....1 No.....2	WAITING_TIME
18	I have difficulty asking the doctor questions	Yes.....1 No.....2	DR_CAREGIVER_RELATIONSHIP
19	Does a lack of services limit the care and support your caregiver get?	Yes.....1 No.....2	LACK_SERVICES

SECTION C. Barriers to health care			
20	Prescribed drugs for caregivers are difficult to acquire	Yes1 No2	PRESCRIBE_DRUGS
21	There are enough recreational facilities for caregivers	Yes1 No2	RECREATIONAL_FACILITIES

22	There are not enough mental health practitioners in the hospital	Yes1 No2		SPECIALIST _DEFICIEN CY
23	There are not enough beds to admit caregivers for long	Yes1 No2		LIMITED_B EDS
24	The sanitary condition in the wards is bad	Yes1 No2		POOR_SANI TARY
25	I have been discriminated against by health professionals because of my caregiver's mental health problems	Yes.....1 No.....2		DISCRIMIN ATION
26	Health personnel have disrespected me on several occasions because of my mental health problems	Yes1 No2		DISRESPEC T
27	I am angry with the way the hospital have separated mental health caregivers	Yes1 No2		SEPARATIO N_CAREGI VERS
28	I am shocked by how health personnel and other people react to mental health caregivers at the hospital	Yes1 No2		LACK_EMP ATHY_CAR EGIVERS
29	I have been avoided and insulted me because of my caregiver's mental health problems	Yes1 No2		AVOIDED_I NSULTED

SECTION E. Quality healthcare delivery indicators

30	I receive prompt attention for my caregiver	Good.....1 Poor.....0		PRT_ATT
31	The doctor or medical assistant's examination is excellent	Good.....1 Poor.....0		DR_EXAM
32	I am provided with diagnosis information	Good.....1 Poor.....0		DIAGNOSIS
33	The health professional provides treatment advise for me to implement	Good.....1 Poor.....0		TRTMEN T_ADVICE
34	The health professional provides treatment advise	Good.....1 Poor0		TREATMEN T_ADVICE
35	I have privacy during consultation	Good1 Poor.....0		PRIVACY
36	Availability of all prescribed drugs	Good1 Poor0		ALL_PRES DRUGS

Thank you for responding to the survey!!!!!!!!!!!!!!

Appendix III: Approval letter from Ghana Health Service Ethics Committee