

**UNIVERSITY OF GHANA**

**COLLEGE OF HUMANITIES**

**COMMUNITY-BASED MENTAL HEALTH CARE: EXPERIENCES OF  
PROFESSIONALS AND FAMILY CAREGIVERS IN THE EASTERN REGION  
OF GHANA**

**BY**

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**DECLARATION**

This is to certify that this thesis is the result of an investigation led under supervision by Akosua Serwaah Bonsu, an MPhil Candidate in the Department of Psychology, University of Ghana towards the honour of Master of Philosophy in Clinical Psychology Degree.

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**DEDICATION**

To my dearest sister, Eva Osei Bonsu for believing in me.

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## **LIST OF ABBREVIATIONS**

CBMH      Community-Based Mental Health Care

CMHO      Community Mental Health Officer

INST      Institutional (Care)

WHO      World Health Organisation

**ABSTRACT**

Mental health services are considerably underfunded. In recent years, Ghana has attempted a shift to community-based mental health care, deemed to neutralise challenges identified with institutional care. Six years after the passage of Ghana's Mental Health Act (Act 846) of 2012, challenges persisted. Meanwhile, studies on caregiver experiences are limited. This study explored the experiences of professionals and family caregivers in community-based mental health care in the Eastern Region of Ghana. It also examined differences in stress, affiliate stigma, wellbeing and coping strategies among community and institutional family caregivers. Using mixed methods approach (concurrent), individual interviews were conducted with 10 mental health professionals and 10 family caregivers. Also, 280 family caregivers provided quantitative data on stress, affiliate stigma, wellbeing and the Brief COPE measures. Qualitative data were examined with Interpretative Phenomenological Analysis, while Multivariate Analysis of Covariance and Hierarchical Multiple Regression analysis were used to evaluate the quantitative data. Qualitative findings revealed that professionals were the most affected by the challenges with community-based mental health care, whereas family caregivers found the high cost of institutional care more worrying. Quantitative findings showed a difference between community and institutional family caregivers in the combined experience of stress, affiliate stigma and wellbeing, with community family caregivers having a higher wellbeing. Stress and affiliate stigma had a negative impact on caregiver wellbeing, though only stress significantly predicted wellbeing. A relationship existed between coping strategies and wellbeing, though community and institutional family caregivers did not differ in the types of coping strategies used. Implications of findings are discussed.

## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background of the study

Mental disorders are debilitating conditions that account for 12-15% of the world's total disability (Thornicroft & Tansella, 2003). According to De Hert et al. (2011), people with severe mental illness, including schizophrenia, have a high death rate, which is 2-3 times more than the general population often due to untreated physical illness. This translates to 13-30 year shortened life expectancy, which has widened in recent decades, even in countries with good health care system (De Hert et al., 2011). The World Health Organisation (2001) stated that, an estimate of 450 million people experience some kind of mental disorder at any given time globally. Mental disorders have great impact on daily life, and account for more than 30% of all years lived with disability (Thornicroft & Tansella, 2003). In Africa, mental disorders constitute 19% of all disability, and 5% of the total burden of disease. It is said to reduce productivity and increase the risk of physical diseases (Monteiro, 2015). Fortunately, there is evidence of treatment success in reducing symptoms and disabilities caused by mental disorders (Corrigan, Druss, & Perlick, 2014).

Patel et al. (2007) found psychopharmacological agents, psychotherapy, among others effective in treating persons with mental disorders in low and middle income countries. Yet, existing evidence (Kohn, Saxena, Levav, & Saraceno, 2004) pointed to a substantial gap in treatment. As high as 44% to 70% of persons living with mental illnesses lack access to treatment in developed countries, where there is an efficient infrastructure for health care. The situation is alarming in developing countries, where over seventy five percent (75%) of sufferers have no easy access to needed mental health care (WHO, 2003). A major problem identified with mental health service delivery is inadequate resource allocation. According to Mackenzie and

Kesner (2016), mental health is severely underfunded, despite its massive burden on global health. The percentage of health expenditure apportioned to mental health ranges from 0.5% in low-income countries to 5.1% in high-income countries (Mackenzie & Kesner, 2016). This situation is observed to exist for quite a long time, tracing back to the history of mental health care.

Approximately between the year 1880 and 1950, the mentally ill were basically offered protective restraint in asylums (Thorncroft & Tansella, 2002). These were remote structures that housed and offered simple requirements for survival of the mentally ill. Limitations of this model included reduced family involvement, inadequate funding, extremely poor standard of treatment and care, isolation of patients and staff, which resulted in progressive loss of potentials, accumulation of deficit symptoms among other negative effects on the mentally ill (Thorncroft & Tansella, 2003). Thus, the need for an appropriate model of treatment that promotes the wellbeing of the mentally ill.

The WHO, therefore, advocates for community-based mental health care to both high- and middle-income countries, as well as low-income countries, which is intended to neutralise challenges identified with custodial or institutional care (Alem et al., 2008). Saxena, Thorncroft, Knapp, and Whiteford (2007) comprehensively described community-based mental health care as any model of care, observation and reintegration of persons with mental illness beyond the hospital by health and social personnel centred in the community. The model takes into account population-based prevention, existing services, access, socioeconomic context, cost, and teamwork (Thorncroft, Deb, & Henderson, 2016). According to WHO (2007), the model seeks to improve access and care, and reduce neglect and human rights violations peculiar to hospital care. Moreover, it allows for tutoring, guidance, and constant support for primary care workers (Saraceno et al., 2007). However, Byrne (2010) noted that patients' reluctance to seek general

health care services, was due to discrimination. According to Tansella, Amaddeo, Burti, Lasalvia, and Ruggeri (2006), although there is no scientific evidence to back the effectiveness of either hospital or community model, there is profound professional opinions and findings from existing studies that support a balanced care (i.e. Community-based care with hospital care playing a backup role). However, differences exist in the implementation of this model in Western and African settings, reflecting on treatment outcomes.

The different elements of service are well-organised in the West, as compared to African settings. Western psychiatric units are established in general hospitals, with the right mix of mental health professionals who deliver outpatient and outreach services (Alem et al., 2008). There are effective partnership with primary health care, social services and other relevant organisations within the local community. Nonetheless, WHO (2003) acknowledged difficulty in identifying mental disorders and treatment in primary care settings in Western countries. According to Makanjuola and Abdulmalik (2011), although the traditional African society characteristically offers a great deal of support, their mentally ill are neglected to roam as vagrants in extreme circumstances. Also, traditional and religious healers have been noted to play significant roles in caring for persons with mental disorders in Africa, although their roles are sometimes seen as controversial. The deficit in the care given to the mentally ill in Africa is linked to inadequate support in terms of personnel, services, and resources (WHO, 2003).

Thornicroft and Tansella (2003) acknowledged resource availability as key to operating an effective community-based model. Primary care staff in low-resourced countries probably provided most mental health services, if not all at their level of health care, employing specialist backup when necessary. The protective role of support systems against psychological distress has been noted by Berkman (2014), adding that, these systems can be measured in terms of a specific relationship structure or sources from which support is obtained.

The family as a support system has been studied extensively. In 2003, WHO acknowledged the family as primary caregivers who provided support for mentally ill relatives. As noted, one out of four families has a minimum of one member with a mental health problem (WHO, 2003). A situation that is usually associated with stress, although difficult to assess and quantify. Consequently, the extent of the burden placed on family members is usually ignored, in spite of its significant effect on family's quality of life (WHO, 2003). Canadian Mental Health Association (2006) explained that, individuals' position in the family determines the magnitude of stress experienced through caring for mentally ill relatives. The Association further asserted that children whose parents had addiction or mental health problems were predominantly distressed, as these children may assume nurturing roles to ailing mother or father, or become a confidante for a parent tending an ailing spouse or child. Nonetheless, other factors have been linked to family's burden in caring for relatives with mental disorders.

According to Leggatt (2002), failure of professionals in mental health to incorporate families in the management and care plan for their mentally ill relatives affects family caregivers. Professional mental health workers in Western societies fail to recognise the role of family caregivers, and hold them liable for patients' illness in some cases (Spaniol, Zippel, & Lockwood, 1992). A blame practice reported to be declining due to neurological explanations for mental illnesses (Leggatt, 2002). Yet, patient confidentiality, and the lack of skills in working with families have been implicated for family exclusion in Western countries, and believed to have contributed to advances of self-help organisations whose activities have not been adequately evaluated or recognised (Leggatt, 2002). Family inclusion, however, takes a different dimension in Africa.

African societies do not exclude families in managing persons with mental disorders, and have no confidentiality issues (Leggatt, 2002). The unique contribution towards patients' recovery is generally disregarded in both settings. Yet, family members provide intervention in emergency situations, provide shelter, assist with daily activities, among others, and in some cases, are more conversant with and may even have a better understanding of some aspects of their relative's illness than professionals (Canadian Mental Health Association, 2006). To Leggatt (2002), family caregivers in developing countries, for instance, play a vital role in the reintegration of patients in society due to lack of rehabilitation professionals. In effect, the diverse role of families has been confirmed beneficial to patients, their families, and the mental health system at large (Canadian Mental Health Association, 2006). Thus, the need for recognition and support, to lessen their burden and promote wellbeing.

Northouse, Katapodi, Schafenacker, and Weiss (2012) revealed a significant interconnection between family caregiver's wellbeing and that of their patients. According to Vitaliano and Katon (2006), prolonged experience of stress due to the demands of caring, has a possible impact on family's daily living, health, career, finances, and social relations. Other factors known to affect families and mental health service delivery have been identified by researchers.

Beliefs and attitudes, often intensify families' burden with extra guilt (Spaniol et al., 1992). Kyei-Mensah (2016) reported that, the stigma attached to mental disorder results in sufferers' exclusion from communities, leading to deprivation of basic human rights, with rights to health, social and economic wellbeing inclusive. Stigma is said to be strongly rooted in cultural beliefs. For instance, Sokhela (2016) noticed relationships formed between mental disorders and witchcraft in certain communities in South Africa, which obviously promoted stigma. Moreover, Jimenez, Bartels, Cardenas, Daliwal, and Alegría (2012) noted that, beliefs

enfolded mental disorders were influenced by race or ethnicity. In addition, Okasha (2002) acknowledged the significant effect of poverty on mental health service delivery in Africa. Meanwhile, there is evidence of attempts to improve mental health services in Africa, despite existing challenges and limitations.

Lund et al. (2015) gave an account of the efforts made by Africa Focus on Intervention Research for Mental Health (AFFIRM) to narrow the treatment gap for mental disorders, and also build capacity for research targeted at intervention in sub-Saharan Africa. Another attempt was by United Nation's Millennium Development Goals (MDGs), although a latter report by Eaton, Kakuma, Wright, and Minas (2014) indicated unmet goals. Apparently, the MDGs had specific goals for overcoming physical diseases than mental disorders. Obviously, the impact of mental disorders was less thought of due to limited attention to mental health in Africa (Gureje and Alem, 2000), even though Sachs and Sachs (2007) strongly defended the course of the MDGs.

On the other hand, Eaton et al. (2014) noted that, major advances could be made in general health outcomes if mental health needs are adequately taken care of, and vice versa. The limited attention to mental health in Africa, has been linked to the numerous problems posed by communicable diseases and malnutrition, thus, directing available resources for intervention (Gureje & Alem, 2000). The effect of inadequate resources on mental health service delivery has been reported in some African countries, including South Africa, Malawi and Uganda (Marais & Petersen, 2015; Ssebunnya, Kigozi, Kizza, & Ndyanabangi, 2010; Udedi, 2016).

### **1.1.1 Mental Health in Ghana**

Ghana, like most developing countries, has limited resources allocated to mental health. According to Akapule (2015), Ghana has an estimated three million people living with mental disabilities, and yet, has a treatment deficit of 98%. Roberts, Asare, Mogan, Adjase, and Osei

(2013) disclosed a budget of 1.4% of government's total health expenditure for mental health in Ghana, compared to a significant percentage allocated to physical health. The ripple effect of this is a poor mental health service delivery, contrary to what Ghanaians expected after the passage of Mental Health Act 846 of 2012 (Akapule, 2015).

The history of Ghana's mental health policies, dates back to 1888. An era that saw the enactment of the Lunatic Asylum Act by colonial authorities to confine persons with mental disorders in asylums, thus, decongesting prisons where they were kept (Kofie & Montana, 2017). This marked the beginning of formal government mental health services. This law remained in use until the passage of NRCD 30 in 1972, which focused on a relatively advanced form of institutional care (Kofie & Montana, 2017). Kofie and Montana, however, noted that, although attempts were made in 1996, the NRCD 30 had never been amended until 2012. Moreover, Roberts et al. (2013) narrated how drafting of a new Act lasted between 2004 and 2006, and continued to be modified until it received presidential assent in May 2012. The current mental health act, finally became a law (Mental Health Act 846 of 2012) on 1st of December, 2012. A new act was deemed necessary because the Mental Health Decree NRCD 30 had become outdated, and was no longer found to offer better standards for mental health practice and legislation (Kofie & Montana, 2017).

Object 2 (c) of Act 846 of 2012 emphasises community-based mental health care. This seeks advancement in mental health and the delivery of humane care, ensuring that treatment and rehabilitation is conducted in less restrictive settings. Thus, a move to deinstitutionalize mental health care. The state of mental health prior to Act 846 of 2012 was described as centralised, medicalised, institutionalised, under resourced, and stigmatised, with reports of human rights abuses, resulting in poor quality mental health care by Dr. Akwasi Osei (Chief Executive Officer, Mental Health Authority) in December, 2015. An in-depth depiction of the deplorable

state of the mental health system in Ghana was provided by Roberts, Mogan, and Asare (2014).

The new paradigm was therefore envisioned to address identified inefficiencies.

Although several advances have been made following the passage of Act 846 of 2012 such as; attempts to downsize the major psychiatric institutions through repatriation of overstayed patients (“Accra Psychiatric Hospital”, 2016), incorporating mental health in primary health care (GNA, 2014), successful collaboration with the community, example Basic Needs (Wilson & Somhlaba, 2017), appointment of Regional Mental Health Co-ordinators and Regional Mental Health Sub-Committees (Bonsu, 2015), orientation programs, trainings and workshops, there are practical challenges (Akapule, 2015). The delay of vital structures and resources stipulated in the Act to help implement policies has a major influence on community-based mental health care which is being implemented in Ghana. For instance, Review Tribunal to assess complaints in line with detention under Act 846 of 2012 among others have not materialised.

Obviously, Ghana is nowhere near delivering quality, affordable and timely mental health services required to earn public confidence in the mental health sector (Chigwamba, 2008). Yet, Lynch (2002) noted the link between unfavourable work conditions and employees’ physical and psychological wellbeing, and the reverse impact on work output. Meanwhile, Doku, Wusu-Takyi, and Awakame (2012) projected these challenges ahead of the passage of Act 846 of 2012, which were linked to factors such as political, financial, advocacy, and system discrepancies. Similarly, Walker (2015) identified financial limitations, delayed endorsement of Legislative Instrument (LI) among others as challenges for implementation, and stated that, improvement in other domains including infrastructure and effective tutoring could materialise once finances were secured. Again, Sodzi-Tettey (2016) suggested a reconsideration of free mental health service delivery amidst inadequate resources as a nearby measure to sustain the mental health

system in Ghana. Certainly, the effect of adequate political and economic inputs on levels of performance cannot be overstated (Wild, King, Chambers, & Harris, 2012).

## **1.2 Problem Statement**

The passage of Act 846 of 2012 put a smile on the faces of mental health sympathisers, and was deemed by both mental health professionals and family caregivers, including patients as a means to address the unfavourable experiences in the field (Chibaro, 2013). Approximately six years on from passing this Act, certain unfavourable experiences that pre-existed still live on. There is a frequent shortage of free Psychotropic medications, high service charges, and lack of funds to support community mental health activities. Family caregivers have to live with patients despite low socioeconomic status and or busy work schedules. There are no well-structured community facilities such as halfway homes, clubhouses, and self-help groups to engage or empower patients with the skills necessary for adaptation.

Professionals offering community care are limited and continue to improvise with inadequate or unavailable resources. Explaining to The Mirror (Broadcasting and Media Production Company in Accra, Ghana), Dr. Akwasi Osei (Mental Health Authority) noted that the frequent shortages of appropriate psychotropic medications, even in major facilities meant that patients had to purchase them elsewhere (Awaf, 2010). Dr. Akwasi Osei added that, the situation makes treatment expensive, implying that more individuals with mental health challenges would unceasingly roam our streets, as their families may be unable to afford treatment cost, an observation that cut across the various regions in Ghana.

The delay of necessary structures and resources for implementing community-based mental health care may have a significant impact on professionals and family caregivers. Not eliminating its direct impact on patients. A success of which could partly account for the relevance of Ghana's Mental Health Act 846 of 2012. Despite these challenges, limited studies

have been done on the experiences of individuals who offer care to persons with mental illness. Meanwhile, most existing studies focused on the challenges with mental health care. Also, there are inconsistencies in the findings of previous studies. Consequently, it was necessary to investigate the perspective of community-based mental health care providers (professionals and family caregivers), and further examine the experiences of family caregivers when their mentally ill relatives were institutionalised or received community-based mental health care. This study was conducted in the Eastern Region of Ghana.

### **1.3 Aim and Objectives of the Study**

The main aim of this study was to explore the experiences of professionals and family caregivers in community-based mental health care settings in the Eastern Region of Ghana.

The specific objectives were to:

1. Explore the experiences of professionals and family caregivers offering community-based mental health care in the Eastern Region.
2. Investigate coping strategies employed by professional and family caregivers.
3. Assess differences in stress, affiliate stigma, wellbeing and coping strategies between community and institutional family caregivers.
4. Examine the impact of caregiver stress and affiliate stigma on caregiver wellbeing
5. Investigate the relationship between coping strategies and caregiver wellbeing.

### **1.4 Relevance of the Study**

This study seeks to reveal experiences of mental health professionals and family caregivers involved in community-based mental health care. The findings are expected to inform policies to improve mental health service delivery. Also, the results are deemed to advise programs to safeguard the wellbeing of professionals and family caregivers. The study's

outcome and recommendations are supposed to lay a foundation for future research, broaden the scope and add to the few studies done on Ghana's mental health system (Read & Doku, 2012).

### **1.5 Scope of the Study**

This study explored experiences of mental health professionals and family caregivers of persons with mental illness. It also examined the difference between community and institutional family caregivers in the Eastern Region of Ghana on stress, affiliate stigma, wellbeing, and coping strategies. Again, the impact of caregiver stress and affiliate stigma on caregiver wellbeing, as well as the relationship between coping strategies and caregiver wellbeing were investigated. However, the study did not investigate the above stated variables in persons with mental illness.

### **1.6 Research Questions**

1. What are the experiences of professionals and family caregivers offering community-based mental health care?

Specifically, the study aimed to explore the following:

- a. The benefits associated with CBMH
- b. Experienced challenges with CBMH
- c. Respondents' thoughts on improving CBMH
- d. Existing challenges with INST
- e. The mental health care model associated with more stress
- f. Respondents' preference for INST and CBMH
- g. Respondents' thoughts on shift from INST to CBMH
- h. Effect of CBMH on caregiver finances, career, activities of daily living and wellbeing
- i. Society's attitude towards caregivers of persons with mental illness

- j. Observed effects of society's attitude towards caregivers of persons with mental illness
2. What are the coping strategies employed by professional and family caregivers?
3. What are the differences in stress, affiliate stigma, wellbeing and coping strategies between community and institutional family caregivers?
4. What is the impact caregiver stress and affiliate stigma on caregiver wellbeing?
5. What is the relationship between coping strategies and caregiver wellbeing?

### **1.7 Organisation of the Study**

The study is presented in five chapters. An extensive appraisal of prevailing related studies on community-based mental health care, together with theory of adoption, among others are presented in Chapter two. Chapter three focuses on the methodology of the study. Thus, a description of the research design, study area, population, sampling and sampling technique, measures, research procedure, data analysis, and ethical considerations are outlined. Chapter four presents results of the study. The last chapter (five) contains a discussion of findings, implications for clinical practice, theoretical implication, limitations, recommendations for future studies, and conclusions.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

The present study as noted in the preceding chapter aimed at exploring the experiences of professionals and family caregiver in community-based mental health care in the Eastern Region of Ghana. This chapter presents a model to help explain caregiver experiences. Also, related studies on community-based mental health care, caregiver experiences, wellbeing and coping have been extensively reviewed. In addition, this chapter presents the rationale of the study, statement of hypotheses, and operational definition of key terms and concepts.

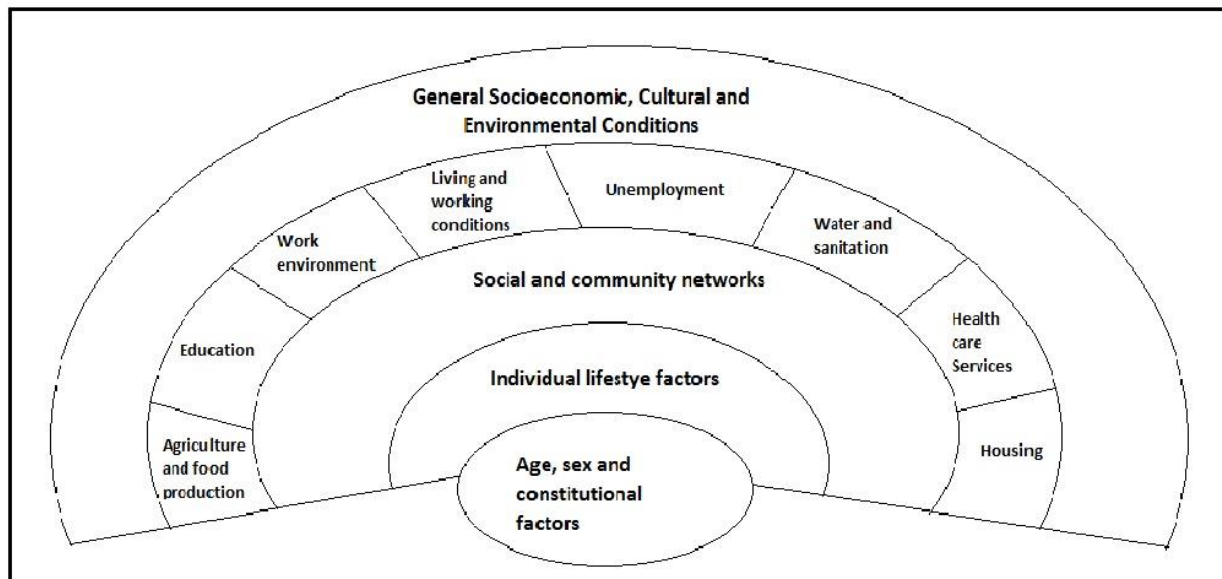
#### 2.2 Theoretical Framework: Social Model of Health (Dahlgren & Whitehead, 1991)

Dahlgren and Whitehead's theory attempt to map a connection between individuals, their environment and disease. The theory argues that people are surrounded by a lot of factors that influence their health, and that these factors can be altered or improved. According to Modranka and Suchecka (2014), determinants of a population's general health can be conceptualised as Dahlgren and Whitehead's rainbow-like layers of influence.

The first of these layers is peculiar behavioural factors such as smoking habits. Second is social and community influences where individuals are influenced by their peers and immediate community through their interrelations. This second layer may or may not offer reciprocal support for members in unfavourable conditions. The third layer consists of structural components, including shelter, working conditions, access to services and delivery of essential facilities. The last layer serves as a mediator of population health, and exists in the overall society, consisting of economic, cultural and environmental influences. To Modranka and Suchecka (2014), disparities in a population's health depend on the distribution of particular

determinants. The arguments put forward by the social model of health are supported by the social determinants of health theory often utilised by WHO to explain population health, including mental health (Dean, Williams, & Fenton, 2013).

De Maio, Mazzeo, and Ritchie (2013) explained that, social determinants of health entail characteristics and ways by which health is affected by societal conditions. These conditions proceed from community elements to a more macro-level political outlook, biases in which amounts to social injustice, which contributes to diseases. Therefore, knowledge of the effect of biases in societal conditions must be relevant to policy, just as their reduction is an ethical necessity. This view is backed by various studies (Kawachi & Kennedy, 1999; Pickett & Wilkinson, 2015; Wilkinson & Pickett, 2009). Social model of health was therefore relevant to the present study to determine the environmental influence on caregiver wellbeing, in the area of community-based mental health care in Ghana. Figure 1 describes the social model of health, which guided the present study.



*Figure 1: Theoretical Model of the Study*

## **2.3 Review of Related studies**

This subsection of literature review focuses on existing studies on community-based mental health care, caregiver experiences, wellbeing and coping. Furthermore, pertinent findings in line with the aim of the present study are emphasized. This is to help gain a better understanding of the phenomenon under study.

### **2.3.1 Community-Based Mental Health Care**

Community-based mental health care is accredited as a system of care in which care provision chiefly rests on the patient's community rather than a psychiatric facility with varied services from one country to another (Seshi Kumar, 2011). Over the years, studies have aimed at investigating the experiences with this model, its effectiveness, implementation strategies, and challenges among others. Generally, community-based mental health care is widely deemed effective for treating mental illness (Wiley-Exley, 2007). In 2010, Hanlon, Wondimagegn, and Alem outlined the diverse versions of the model. These varied from specialist assertive outreach groups to variations in how mental health is fused with primary health care. Integration strategies of the model include: joint clinics conducted by primary care workers and mental health nurses; mental health nurses operating in primary care settings; and primary care workers delivering utmost mental health services with intermittent support from a mental health specialist (mostly psychiatrists and psychiatric nurses). It is however worth noting that, the latter is common in low-income African countries, the implementation of which is associated with some challenges.

For instance, Saraceno et al. (2007) discussed an existing public-health priority outline and consequence of the grant to include: issues with mental health service decentralisation; challenges in implementing mental health care in primary care sceneries; a limited right mix of staff trained and overseen in mental health care; and the general paucity of public-health attitudes in mental health leadership, which are believed to hamper the effectiveness of mental health

service delivery. Clearly, obstacles to improving mental health services could be conquered through the creation of adequate political will, which increases the handiness and access to civilised mental health care. Likewise, policymakers could be influenced by beliefs or motivations based on political will to act and to build or hinder change. This stance was duly supported by Eustache and Lasante (2016), with their finding on the effect of political will and policy on developing and implementing the community-based mental health care model in low to middle income states. Both studies drew attention to possible solutions to the realisation of an appropriate mental health system and a well implemented community-based mental health care model.

The issue of inadequate funding as a factor hampering implementation of community mental health care in Africa cannot be overemphasised (Hanlon et al., 2010). Congruently, there are challenges with continuous supervision and training for primary care workers, the high staff resignation rate due to poor wages and support, among others. Yet, there has been profound support for integrating mental health services into primary health care, with acknowledgement of the demand for collaboration between community mental health care workers and traditional healers, consideration of special needs, social and cultural conditions relevant for a pan-African idea to foster suitable mental health services (Alem, et al., 2008) for desirable experiences.

### **2.3.2 Caregiver Experiences in Community-based Mental Health Care**

With regard to experiences with the model, some inconsistent findings have been recorded by different researchers, which were ascribed to different approaches and the samples used (Pinquart & Sörensen, 2003). To support this claim, while Wiley-Exley (2007) uncovered the model's effectiveness in the management of depression, schizophrenic disorder, panic disorder, or bipolar disorders in adults from low and middle income states and also its cost

effectiveness through a 10-year appraisal of works, Iseselo, Kajula, and Yahya-Malima (2016) found a contradictory evidence on cost based on views gathered from family caregivers.

Moreover, there is a differing verdict on how professionals perceived their practice environment in terms of stress. A demonstration of which was consistent with a study conducted by Farmakas, Papastavrou, Siskou, Karayiannis, and Theodorou (2014). In their study, a descriptive correlational design was employed to engage 248 mental health nurses employed in the public sector (163 nurses from psychiatric hospital, and 85 from community-based settings). Women (56.03) formed the majority of the respondents. About 35% had at least 5 years of experience, 25% had worked for 6–10 years, and almost 22% had more than 20 years of experience.

The findings were suggestive of a mild positive perception of the nurses' practice environment. Nevertheless, nurses working in institutional settings discerned their professional practice environment more negative than their fellow workers in community care. A *t*-test comparison showed substantial variances in the two groups within subdivisions of work motivation ( $P = .04$ ) and leadership and autonomy ( $P = .03$ ). Nurses operating in the community presented higher ratings as compared to their fellow workers in institutional contexts. Work in institutional settings was believed to be associated with more stress, in addition to lowered work inspiration, control and independence. However, the researchers noted how this outcome contradicted the conclusions of previous researchers. Although the reasons for the differences in the professional practice environment (institutional and community) and its possible impact on the nurses' capacity to afford quality care was not assessed, a suggestion for further studies was consistent with other views (Hanrahan, Aiken, McClaine, & Hanlon, 2010; Van Bogaert et al., 2013).

Unlike studies with inconsistent findings, others have underpinned pluses with community-based mental health care. Apparently, Sundin, Nilsson, Waage-Andrée and Björn (2015) reported how nurses perceived safety for people with severe mental illness in community-based mental health contexts. This was said to be in terms of providing support for regaining and maintaining health through good treatment, respect for autonomy and the avoidance of intimidation in the community work environment. Similarly, Seshi Kumar (2011) outlined the advantages of community-based mental health care to include: easily accessible, increased acceptance, cost effectiveness, shortened length of stay in hospital, recuperation of skills needed to aid patients' reintegration, better rehabilitation, multidisciplinary therapy, close connection with different medical disciplines, and family involvement. Yet, there are challenges associated with caregiving.

In a recent study by Iseselo et al. (2016), examination of psychosocial challenges confronting families and their style of coping while caring for relatives with mental disorders in Tanzania isolated stigma as one of the factors influencing caregiver psychosocial wellbeing. Although this is greatly directed at care receivers, stigma attached to mental illness was revealed to enhance psychosocial challenges that affected both patients and their families. Likewise, structural amends within the mental health systems had generated new responsibilities, exposing professionals to fresh sources of tension that could jeopardise the value and constancy of mental health services (Fothergill, Edwards, & Burnard, 2004). According to Talley and Crews (2007), a significant relationship has been observed to exist between caregiving and wellbeing.

### **2.3.3 Relationship between Caregiving and Wellbeing**

In actual fact, Pinguart and Sörensen (2003) provided a good explanation for the differences between psychological and physical health of caregivers and non-caregivers. They further noted potential reasons why many caregivers may not experience more psychological

distress than non-caregivers. This was intended to clear inconsistencies in literature possibly attributed to methodological and conceptual issues, caregivers' perception of caregiving duty, age or condition of the care receiver, and caregiver's ability to cope. Moreover, the study was designed to verify whether observed disparities between caregiver and non-caregiver psychological and physical wellbeing were moderated by caregiving situations such as; relationship with the care receiver, nature of illness and caregiver characteristics such as age and gender. However, facets of caregiving situation, such as the quantity and duration of care delivery were not counted.

The findings from a meta-analysis of studies from developmental and gerontological literature by Pinquart and Sörensen (2003) showed that, the largest distinctions between caregivers and non-caregivers on psychological and physical health were in respect to depression ( $g = .58$ ), stress ( $g = .55$ ), self-efficacy ( $g = .54$ ), and overall subjective wellbeing ( $g = .40$ ). Again, although there were significant differences in physical health, this was negligible ( $g = .18$ ) in favour of non-caregivers. Sizeable discrepancies existed among dementia caregivers and non-caregivers than between unrelated samples of caregivers and non-caregivers, which were too tempted by the calibre of the study, the relationship between caregiver and care receiver, gender, and average age of caregivers. Analysed results indicated that caregiving had impact on caregivers' wellbeing, especially on psychological wellbeing which was in line with the conclusions of recent and dated studies (González-Salvador, Arango, Lyketsos, & Barba, 1999; Northouse, Katapodi, Schafenacker, & Weiss, 2012; Talley & Crews, 2007).

On the other hand, although the concept of caregiving is a familiar part of life and easily understood, knowledge about it had not informed caregiving practice or policy despite the substantial burden and potentially serious health problems that often confront caregivers (Talley & Crews, 2007). For example, Iseselo et al. (2016) unearthed some legitimate concerns in an

explorative qualitative approach involving fourteen (14) family caregivers of persons with different types of mental illness. These were individuals between the ages of 35 and 60, consisting of 5 men and 9 women purposively sampled. While most of these informants had a primary level education, few had secondary. Among them were 5 housewives who depended solely on husbands' source of income and 5 petty traders, all with duration of caregiving ranging from 7 months to 27 years.

Seven themes formed from family caregivers' responses were: financial constraints, disruption of family functioning, patients' safety, conflict with neighbours, lack of social support, stigma and discrimination, in addition to coping and adaptation which family caregivers of patients with chronic illness considered important. In line with stigma and discrimination, Kyei-Mensah (2016) noted some of the consequences of the stigma attached to mental illness to include: sufferers' exclusion from communities, deprivation of basic human rights, such as the rights to health, social and economic wellbeing. Ultimately, the findings of a previous study confirm the retarding nature of stigma on recovery (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). By association, the stigma and discrimination directed towards persons with mental illness transcends to caregivers (Yin et al., 2014). Following these thoughts, Mak and Cheung (2008) defined affiliate stigma as the degree of self-stigmatisation among relations of an affected interest group, while developing a scale to assess same.

Nevertheless, Werner, Mittelman, Goldstein, and Heinik (2012) observed that, in existing related studies, caregivers' view of stigma was linked with an added burden. Eventually, Iseselo et al. (2016) confirmed stigma as one of the factors that influence caregiver psychosocial wellbeing. Evidently, a previous study conducted by Liu (2011) which examined the connection between perceived stigma and depressive symptoms found that, perceived stigma among caregivers correlated with the experience of depressive symptoms, a situation that was

intensified with a heightened perception of stigma. Yet, Kim, Greenberg, Seltzer, and Krauss (2003) had mapped a significant relationship between caregiver wellbeing and coping.

### **2.3.4 Relationship between Caregiver Wellbeing and Coping**

Coping, as defined by Grover, Pradyumna, and Chakrabarti (2015) denotes strategies employed to endure internal or external pressures thought to outweigh an individual means to overcome. However, Grover et al., (2015) went further to acknowledge and caution on a poor quality of life for individuals who were unable to cope effectively with the stress associated with caregiving. Examples of such strategies employed by caregivers of persons with mental illness include: confrontation, distancing, self-control, acceptance of responsibilities, escape avoidance, and positive reappraisal, in addition to the use of social support and problem solving, which were duly recognised as the most commonly used in the descriptive study by Pompeo, Carvalho, Olive, Souza, and Galera (2016). Moreover, some studies have proceeded to recommend certain strategies as more effective, an example of which are studies that confirm the effectiveness of acceptance coping (Cook & Hayes, 2010; Kohl, Rief, & Glombiewski, 2013). It was therefore usual, for Iseselo et al. (2016) to identify faith and acceptance as two of the most frequently used strategies for coping among caregivers of persons with mental illness, as they examined the psychological problems and coping of the caregivers. Thus, while some learned to accept their patients' situation to prevent dissatisfaction and disappointment, others pursued religious backing as a means of promise and encouragement.

## **2.4 Summary of Related Studies**

Generally, studies support the effectiveness of community-based mental health care (Wiley-Exley, 2007), although Hanlon et al. (2010) noted that studies on this model is limited. Sundin et al. (2015) noted patient's safety in community mental health settings, whereas some

professionals rated working in community settings less negative and less stressful as compared to institutions, contrary to findings from other studies (Farmakas et al., 2014). Moreover, increased work inspiration, control and independence have been associated with community work (Farmakas et al., 2014). Wiley-Exley (2007)'s evaluation of community-based mental health care in low and middle income countries found the model cost effective, although Iseselo et al. (2016) uncovered otherwise, based on family caregivers' views.

Caring for the mentally ill has been deemed stressful (Fothergill et al., 2004), with evidence showing a connection between caregiving and wellbeing (Talley & Crews, 2007). Although caregiving has an effect on physical wellbeing, psychological wellbeing has been found to be much affected (González-Salvador et al., 1999; Pinguart & Sörensen, 2003; Talley & Crews, 2007). Factors influencing caregiver psychosocial wellbeing include stigma, which is greatly directed at care receivers (Iseselo et al., 2016), for which most caregivers resort to acceptance and faith as means of coping. However, a relationship between coping and caregiver wellbeing is confirmed (Kim et al., 2003). Consistently, the need for adequate resources for effective community-based mental health service delivery in Africa has been noted by most researchers, who often implicated policy and political will (Alem et al., 2008; Eustache & Lasante, 2016; Hanlon et al., 2010; Saraceno et al., 2007).

Methodologically, most studies relied on single research designs (Alem et al., 2008; Farmakas et al., 2014; Iseselo et al., 2016; Pinguart & Sörensen, 2003; Saraceno et al., 2007; Sundin et al., 2015; Wiley-Exley, 2007). Moreover, conceptual issues and sample size have been linked to inconsistencies in findings of researches done in community-based mental health care (Pinguart & Sörensen, 2003). For instance, there is limited comparative studies done. A manifestation of this could be linked to a study conducted by Pinguart and Sörensen (2003). In their study, an evaluation of both community-based caregivers and institutional caregivers, and a

consideration of differences in the extent of their care delivery could have helped deepen understanding of differences between caregivers' psychological and physical health.

Further, views of family caregivers could have augmented conclusion made from professionals on patients' safety in the community setting by Sundin et al. (2015). It is expected that the sample used for a study has sufficient information, considering the aim of the study (Malterud, Siersma, & Guassora, 2016). Thus, Alem et al. (2008)'s findings on views on community-based mental health care in sub-Saharan Africa from twenty (20) respondents, most of whom were psychiatrists and practicing professors of psychiatry may not be enough to convince the scientific community. Suggestively, community-based mental health workers could have revealed their lived experiences, and offered pragmatic suggestions for improvement in most of the studies reviewed. It is therefore in line for professionals in some cases to blame a lack of solution to their concerns on methods employed by existing studies in the field, which have inadequately captured their lived experiences (Farmakas et al., 2014).

## **2.5 Rationale of the Study**

Literature reviewed in the area of community-based mental health care, caregiver experiences and wellbeing revealed inconsistencies, including the cost effectiveness of community -based mental health care and stressful work environment (community and institutional). Also, previous studies to some extent did not focus on professionals and family caregivers delivering community-based mental health care to investigate experiences with the model. Moreover, the methods used by existing studies were inadequate to reveal the lived experiences of caregivers. Hence, there was a need to fill these gaps. This study, therefore explored the in-depth experiences of professionals and family caregivers, investigated differences in stress, affiliate stigma, wellbeing and coping strategies of community and institutional family caregivers, examined the impact of caregiver stress and affiliate stigma on

caregiver wellbeing, as well as the relationship between coping strategies and caregiver wellbeing with mixed methods approach.

## 2.6 Statement of Hypotheses

H1: Perceived stress, affiliate stigma and wellbeing will significantly differ between community and institutional family caregivers, after controlling for potential covariates. [This hypothesis was informed by a previous study that established differences in professionals' perception of their practice environment in terms of stress (Farmakas et al., 2014)]

H1a: Perceived stress will be significantly higher among community family caregivers than it will be among institutional family caregivers.

H1b: Affiliate stigma will be significantly higher among community family caregivers than it will be among institutional family caregivers.

H1c: Community family caregivers will report significantly lower wellbeing than institutional family caregivers.

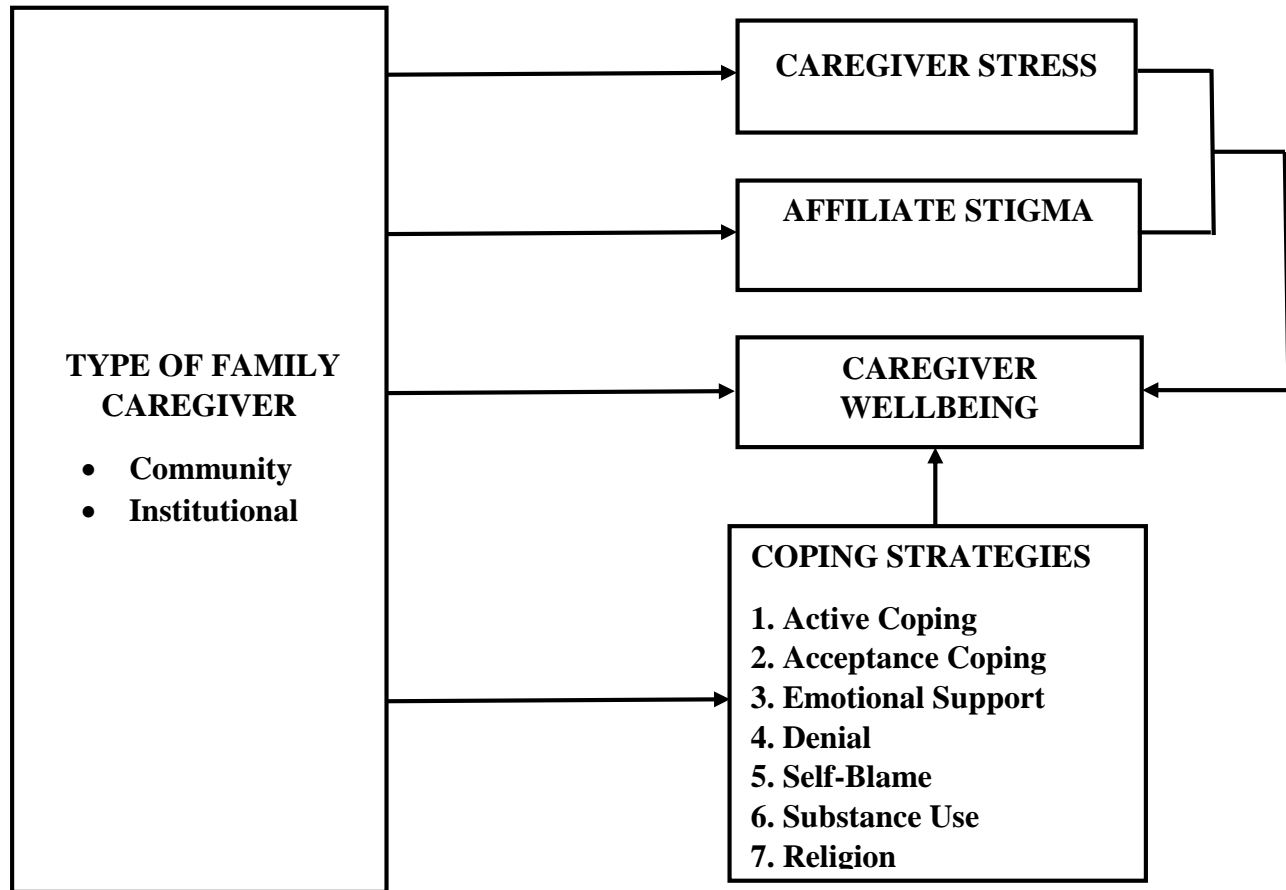
H2: There will be differences between community and institutional family caregivers in the types of coping strategies used to manage stress controlling for potential covariates. [This hypothesis was informed by the findings of a previous study that partially confirmed differences in the types of coping strategies used among two groups (Salifu Yendork & Somhlaba, 2014)]

H3: Caregiver stress and affiliate stigma will negatively predict caregiver wellbeing, after controlling for potential covariates [This hypothesis was informed by a previous study that revealed the impact of both objective and subjective stressors on caregiver wellbeing (Son et al., 2007), and another study that found a relationship between perceived stigma and depressive symptoms among caregivers (Liu, 2011)]

H4: There will be a significant relationship between coping strategies and caregiver wellbeing controlling for potential covariates. [This hypothesis was informed by a previous study that demonstrated a relationship between coping and caregiver wellbeing (Kim et al., 2003)]

## **2.7 Conceptual Model of the Study**

There is inadequate funding for mental health services in Ghana with a delay of vital structures to facilitate mental health service delivery, and for that matter community-based mental health care. It was therefore projected that the stress associated with the lack of appropriate resources and necessary structures to augment community-based care, as well as perceived affiliate stigma from society would lead to a more negative experience for community family caregivers than it would be among institutional family caregivers. Consequently, community family caregivers were expected to report a lower wellbeing than institutional family caregivers. Moreover, it was anticipated that the types of coping strategies used to manage stress by these two groups of family caregivers would predict wellbeing (i.e. higher or lower wellbeing). These associations are illustrated in the ensuing model.



*Figure 2: Summary of the hypothesized relationships between the study variables*

## 2.8 Operational Definitions of Terms

1. ***Institutional care:*** Institutional care denotes care offered to persons with mental illness on admission in a mental health facility or unit.
2. ***Primary health care:*** Refers to care accessed from a general health facility, usually delivered by non-specialists.
3. ***Family caregiver:*** For the purpose of this study, family caregiver implies a family member who accepts responsibility for a mentally ill relative.
4. ***Institutional family caregiver:*** Refers to a family member who adopts responsibility of a mentally ill relative who has been admitted to a mental health facility or unit.

5. *Community family caregiver*: Refers to a family member who shoulders responsibility of a mentally ill relative receiving care at home.
6. *Affiliate stigma*: This refers to stigma experienced by an individual by virtue of his or her association with persons living with mental illness. This was measured with the Affiliate Stigma Scale (Mak & Cheung, 2008).

## CHAPTER THREE

### METHODOLOGY

#### 3.1 Introduction

This chapter illustrates the method that was used for this study. It highlights the research design, study area, study population, sampling and sampling technique, measures, research procedure, data analysis, and ethical considerations.

#### 3.2 Research Design

Mixed methods approach was used for this study. Johnson and Onwuegbuzie (2004) described it as the third research paradigm in educational research which frequently resulted in superior research. Johnson and Onwuegbuzie (2004) were of the view that, mixed methods (quantitative and qualitative) help to make both an objective social science inquiry, and also yields detailed, rich and thick (empathic) description of a phenomenon. The timing for this approach was concurrent, which allowed for adequate data to be collected within a shorter period (Creswell, 2013). Mixed methods approach was particularly useful due to the exploratory nature of the study and the quest for further comparison (Kelle, 2006).

The qualitative aspect of the study assessed the experiences of both professionals and family caregivers. This was facilitated by the phenomenological research design to gain an understanding of the meanings that professionals and family caregivers ascribed to their experiences with community-based mental health care (Creswell, 2013). Thus, the researcher was able to identify the essence of experiences described by caregivers concerning community-based mental health care (Creswell, 2007).

In addition, a quantitative investigation was conducted on family caregivers to gain an objective explanation of caregiver experiences using predictions about differences in stress,

affiliate stigma, wellbeing and coping strategies among community and institutional family caregivers. Besides, predictions about the impact of caregiver stress and affiliate stigma on caregiver wellbeing, and the relationship between coping strategies and caregiver wellbeing were tested. Family caregivers were chosen for this supplementary enquiry based on their significant roles in the community setting, and in the care of persons with mental illness, which are often ignored despite their burden as confirmed by existing studies (Gibson, Kelly, & Kaplan, 2012; Vermeulen et al., 2015). The perceived relationships among these variables were examined and analysed using statistical procedures (Creswell, 2013). A cross-sectional study design was employed. This also provided information about existing relationships between the two models of mental health care and the proposed study variables.

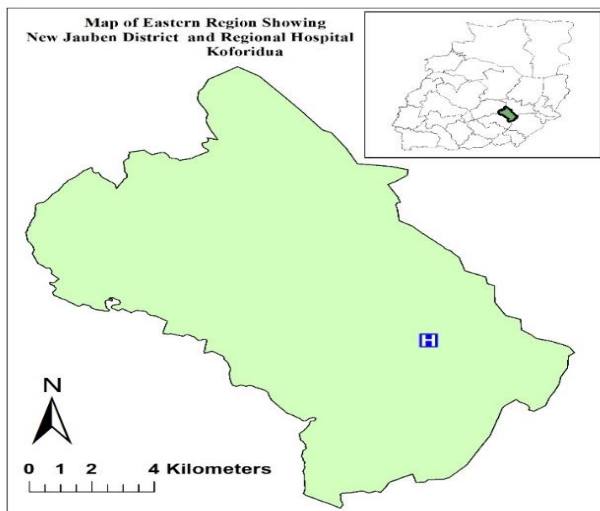
### **3.3 Study Area**

The present study was conducted in the Eastern Region of Ghana, specifically in the New Juaben Municipality, which houses the regional capital, Koforidua and the Eastern Regional Hospital. The Eastern Region of Ghana was chosen for the present study because aside the three (3) major psychiatric hospitals in Ghana, the region has a relatively well-structured system for the delivery of both community and institutional mental health services. It lies between latitude 6.0°N and 7.0°N. It occupies the area north of the Greater Accra and Central Regions, east and south of the Ashanti Region, west of the Volta Region and south of the Brong-Ahafo Region. Eastern Region has a land surface of about 19,323km<sup>2</sup>, representing 8% of the total land mass of Ghana, with sixty percent of it, made up of tropical forest and the remaining 40% predominantly Guinea savannah (Ghana Statistical Service, 2012).

Moreover, per the projections of the 2010 population and housing census, a total of 2,982,845 persons lived in about 3,387 communities in 26 administrative districts in the region. Out of the stated population, 43.4% (1,241,849) live in urban whereas 56.6% (1,619,556) live in

rural areas. The annual population growth rate and population density were reported to be 2.1% and 148 per km<sup>2</sup> respectively. A report by Amankwah (2016) indicated that, the region has a relatively well developed health infrastructure. A total of 25 hospitals were distributed across 18 districts within the region. These included 16 Ghana Health Service and 9 quasi-government facilities (7-CHAG, 1-VRA and 1-GCD).

Amankwah (2015) noted in a report that the New Juaben municipality being the smallest among the 26 districts in the region has a land area of 110.0 square kilometres, and a total population of 208,127. There are three other health facilities located in New Juaben aside the Eastern Regional Hospital that provides community-based mental health services. The Eastern Regional Hospital has a well-structured mental health unit that offers both institutional and community-based mental health services, and serves as the main referral point for all mental cases in the region. For instance, towards the end of December 2015, a total of 2,873 cases, representing 1.38% of the district's population was recorded at the Eastern Regional Hospital (Amankwah, 2015). The map below shows New Juaben Municipality and the Regional Hospital.



**Figure 3: Map of Eastern Region Showing Study Area**

### 3.4 Study Population

Owing to the study's quest to explore experiences of professionals and family caregivers in community-based mental health care, a population that comprised; Registered Mental Health Nurses (RMNs), referred to as Community Psychiatrist Nurses (CPNs) once they are assigned to work in the community; Community Mental Health Officers (CMHOs); and Family Caregivers of persons with mental illness in the Eastern Region was chosen. A sample was drawn purposively and conveniently for the study.

### 3.5 Sample and Sampling Technique

The qualitative aspect of the study sampled 10 professionals and 10 family caregivers for individual interviews. This number was appropriate as respondents were presumed to have sufficient information, considering the study's aim, sample specificity, guided theory, quality of dialogue, and analysis strategy. Malterud et al. (2016) referred to this as the concept of "information power", and commended its use in determining sample size for qualitative studies instead of the concept of saturation.

The quantitative aspect of the study sampled 280 respondents per the following outlined steps. With two levels of family caregiver status (i.e., community vs. institutional) and three dependent variables (stress, affiliate stigma and wellbeing) for a quantitative enquiry, an a priori Multivariate Analysis of Covariance (MANCOVA) power analysis using G\*Power 3.1.9.2 (Faul, Erdfelder, Lang, & Buchner, 2017) was conducted to determine the adequate sample size for the study. A sample size of 119 was obtained with a recommended alpha of 0.05, a power of 0.95, and a medium effect size of ( $f^2 = 0.15$ ). This was obtained using G\*Power sample size estimation strategy for MANCOVA (Dattalo, 2008). Thus, the number of covariance ( $g$ ) = 5 was added to the number of groups ( $k$ ) = 2 to derive an adjusted  $df(k + g) = 7$ . Nonetheless, a larger sample size of 280 was chosen to help guarantee external validity of this study. In sum, three hundred

(300) respondents were purposively selected for both the qualitative (20) and quantitative (280) studies based on their willingness to partake in the study and their experience to help the researcher address the research problem (Creswell, 2013; Dattalo, 2008).

### **3.5.1 Inclusion Criteria**

Mental health professionals who met the inclusion criteria were permanent staff and those with no less than 1 year working experience in the Eastern Region. Family caregivers were persons playing significant role(s) in patients' care.

### **3.5.2 Exclusion Criteria**

Although students and service personnel were assisting with the care of persons with mental illness, they were excluded from professionals who participated in the study because they were not fully employed and had less than one year experience. Also, family caregivers who had neglected their mentally ill relatives to roam in the street were not included since that suggested no caregiving. Besides, individuals below the age of 18 were excluded from the study. This is because persons below 18 years are considered children, according to the Children's Act (560), hence not capable of giving consent.

## **3.6 Demographic Characteristics of study Respondents**

For the qualitative aspect, there were twenty (20) respondents for individual interviews. These were made up of 10 mental health professionals and 10 family caregivers. Men (12) formed 60%, of which 4 were professionals and 8 family caregivers. Women (8) formed 40% of the respondents, of which 6 were professionals and 2 family caregivers. The ages of professionals ranged from 26 to 35 years, compared to 22 to 79 years for family caregivers. Five (50%) professionals were involved in community-based care, while five (50%) were offering institutional care, although they all had experience with both models of care. Moreover, 90% of

family caregivers had experience with both models. Professionals had work experience ranging from 1 to 10 years, as compared to 1 to 30 years duration of caregiving by family caregivers.

For the quantitative aspect, 280 respondents were surveyed. There were 140 respondents each for the community and institutional family caregiver groups. The majority of the respondents were women (47 men to 93 women and 50 men to 90 women in the community and institutional groups respectively). In terms of relationship with a patient, a greater number of respondents (54 and 61 for community and institutional family caregivers respectively) were parents, followed by siblings (32 and 22 for community and institutional family caregivers respectively). Individuals caring for their mentally ill parents formed the third largest number of respondents (30 and 22 for community and institutional family caregivers respectively). Distant relatives and carers who were not biologically related constituted “others”, with a total of 32 (15 and 17 for community and institutional family caregivers respectively). Spouses formed the least (9 and 15 for community and institutional family caregivers respectively) of family caregivers in the study.

In terms of education, majority of the respondents had attained primary-JHS education (52 and 51 community and institutional family caregivers respectively), followed by 41 and 33 (community and institutional family caregivers respectively) having O/A level/SSCE education, 17 and 29 (community and institutional family caregivers respectively) having no formal education, 19 and 19 (community and institutional family caregivers respectively) degree holders, and the least (3 and 2 community and institutional family caregivers respectively) having post-graduate education. There were more Christians (132 and 119 community and institutional family caregivers respectively) than Muslims (8 and 16 community and institutional family caregivers respectively), Traditional (0 and 3 community and institutional family caregivers respectively) and other religions (0 and 2) affiliated to by respondents.

In terms of marital status, majority of respondents (72 and 80 community and institutional family caregivers respectively) were married, singles formed the second largest group (29 and 22 community and institutional family caregivers respectively), followed by widows/widowers (21 and 22 community and institutional family caregivers respectively), divorced (14 and 13 community and institutional family caregivers respectively) and family caregivers who had separated (4 and 3 community and institutional family caregivers respectively) formed the least group.

Moreover, quite a large number of respondents (45 and 63 community and institutional family caregivers respectively) earned no monthly income, some respondents (42 and 23 community and institutional family caregivers respectively) earned up to GHc300.00 a month, followed by those who earned between GHc300 and GHc500.00 (27 and 25 community and institutional family caregivers respectively), between GHc500 and GHc1, 000.00 (17 and 16 community and institutional family caregivers respectively) and a few earned above 1,000.00 (9 and 13 community and institutional family caregivers respectively). The average age of respondents was 49.5 and 47.3 for community and institutional family caregivers respectively. Averagely, respondents had spent 10.1 and 7.8 years providing care for persons with mental illness. Table 1 gives a summary distribution of family caregivers for the quantitative aspect of the study.

**Table 1*****Frequencies, Percentages, Means and Standard Deviations of Community and Institutional Family Caregiver Groups' Demographic Characteristics***

Variables	Category	Community Family Caregiver				Institutional Family Caregiver			
		Frequency (%)	M	SD	Range	Frequency (%)	M	SD	Range
Age			49.5	15.7	18 - 92		47.3	13.4	22 - 80
Sex	Men	47 (33.6%)				50 (35.7%)			
	Women	93 (66.4%)				90 (64.3%)			
Number of Years as a Carer			10.1	8.3	1 - 40		7.8	9.2	1 - 46
Relationship with Patient	Child	30 (21.4%)				22 (15.7%)			
	Sibling	32 (22.9%)				25 (17.9%)			
	Spouse	9 (6.4%)				15 (10.7%)			
	Parent	54 (38.6%)				61 (43.6%)			
	Other	15(10.7%)				17 (12.1%)			
Highest Level of Education	No formal Education	17 (12.1%)				29 (20.7%)			
	Primary-JHS	52 (37.1%)				51 (36.4%)			
	O/A Level/SSCE	41 (29.3%)				33 (23.6%)			
	Diploma	19 (13.6%)				19 (13.6%)			
	Degree	8 (5.7%)				6 (4.3%)			
	Post-graduate	3 (2.1%)				2 (1.4%)			
Religious Affiliation	Muslim	8 (5.7%)				16 (11.4%)			
	Christian	132 (94.3%)				119 (85.0%)			
	Traditional Other	0 (0.0%) 0 (0.0%)				3 (2.1%) 2 (1.4%)			
Marital Status	Single	29 (20.7%)				22 (15.7%)			
	Married	72 (51.4%)				80 (57.1%)			
	Divorced	14 (10.0%)				13 (9.3%)			
	Widow/Widower	21 (15.0%)				22 (15.7%)			
	Separated	4 (2.9%)				3 (2.1%)			
Income status per month	None	45 (32.1%)				63 (45.0%)			
	GHC1.00 – GHC300.00	42 (30.0%)				23 (16.4%)			
	GHC300.00 – GHC500.00	27 (19.3%)				25 (17.9%)			

GHC500.00 – GHC1,000.00	17 (12.1%)	16 (11.4%)
GHC1,000.00 and above	9 (6.4%)	13 (9.3%)

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### 3.7 Study Measures

Mixed methods approach for this study necessitated both qualitative and quantitative measures. Thus, the qualitative aspect of the study was assessed with a semi-structured interview guide for both professionals and family caregivers (see Appendix IV). This helped to address objectives one (1) and two (2) of the study. An audio recorder, pen and field notes were additionally useful for the task.

The quantitative aspect was measured with four (4) scales (see Appendix VI). The scales were used to assess caregiver stress, affiliate stigma, caregiver wellbeing and coping strategies to tackle objective three (3), four (4) and five (5). These included; Kingston Caregiver Stress Scale (KCSS), Affiliate Stigma Scale, Care Giver-Wellbeing Scale (CWBS), and the Brief COPE.

#### 3.7.1 Demographic Questionnaire

Respondents provided relevant personal and demographic data. These included: age, sex, religious affiliation, care role (professional or family caregiver), highest level of education, number of years as a carer, marital status and relationship with the patient (family caregivers only). In addition to these, family caregivers indicated their caregiver status (community or institutional), and income status for the quantitative aspect of the study.

### **3.7.2 Quantitative Measures**

#### **3.7.2.1 Kingston caregiver stress scale (KCSS; Hopkins & Killik, 2006)**

The Kingston caregiver stress scale (KCSS) was used to assess stress in caregivers. This is a 10-item primary scale, with three subscales; “Caregiving issues”, “Family issues” and “Financial issues”. The 10 items on KCSS are neutrally worded questions that represent potential sources of stress to the caregiver. According to Hopkins, Killik, and Day (2007), these items measure caregiver stress on a Likert scale from 1 = no stress (coping fine, no problem) to 5 = extreme stress (feeling at “end of rope”, health at risk). It measures caregiving issues with 7 items (1, 2, 3, 4, 5, 6, and 7), family issues with 2 items (8 and 9), and financial issues with 1 item (10). Example of an item on the scale is “Are you having feelings of being overwhelmed, over worked, and/or overburdened?” This scale can be handed to the caregiver for completion, or its items can be read to solicit caregiver’s response. It is used in conjunction with the KCSS Administration and Interpretation Manual, and takes less than 5 minutes. The total score is the sum of the 10 circled responses. A score of 16 and below indicates Mild stress, 16-24 indicates Moderate stress and above 24 indicates severe stress (Hopkins et al., 2007). Pitsikali, Galanakis, Varvogli, and Darviri (2015) reported a Cronbach’s alpha of .85, whereas the present study recorded a Cronbach’s alpha of .92.

#### **3.7.2.2 Affiliate stigma scale (Mak & Cheung, 2008)**

The Affiliate stigma scale was used to measure affiliate stigma experienced by family caregivers in the present study. This measure has 22 items that measure the cognitive, affective and behavioural components of affiliate stigma. Each item is measured on a four point Likert scale format from 1 (strongly disagree) to 4 (strongly agree). Example of an item on the scale is “I worry if other people would know I have a family member with mental illness /intellectual disability”. The maximum score is 88, and the minimum score is 22. The mean score was used to

indicate if one has more of affiliate stigma or not. Hence, respondent whose scores were greater or equal to 55 experienced high affiliate stigma, and those who's scored less than 55 indicated low affiliate stigma. Mak and Cheung (2008) reported a Cronbach's alpha of .94 for 108 caregivers of persons with mental illness. Additionally, Werner and Shulman (2013) reported a value of .93 using 19 of the original 22 items in a study with 170 caregivers. The present study recorded a value of .94 using the original 22 items for 280 family caregivers.

### ***3.7.2.3 Caregiver Well-being Scale, 16-item version (CWBS; Tebb, Berg-Weger, & Rubio, 2013)***

The 16-item shortened version caregiver wellbeing scale was used to assess family caregiver wellbeing in the present study. This version was developed from the original 43-item Caregiver Well-Being Scale (CWBS, Tebb, 1995). The 16-item shortened version has two subscales namely 'Basic needs' (BN), and Activities of Daily Living (AOL), with 8 items in each. According to Rubio, Berg-Weger, and Tebb (1999), CWBS measures family caregiving experience from a strength-based perspective by assessing caregivers' basic human needs and satisfaction with activities of daily living. CWBS is a self-report, measured on a five-point Likert scale ranging from 1 (Rarely) to 5 (Usually). Example of an item on the scale is "Getting enough sleep". The maximum score is 80 and the minimum score is 16. The mean score was used to indicate caregiver wellbeing. Thus, scores greater or equal to 48 indicated high caregiver wellbeing, whereas scores less than 48 indicated low caregiver wellbeing. Tebb et al. (2013) found a good reliability for the subscales and total scale as follows: BN,  $\alpha = .73$ ; ADL,  $\alpha = .74$ ; total scale,  $\alpha = .83$ . Meanwhile, a total alpha of .84 was recorded by the present study.

#### **3.7.2.4 The Brief COPE (Carver, 1997)**

The 28-item Brief COPE was used to assess coping strategies used by family caregivers. This is a shortened version of the 60-item full COPE measure developed by Carver, Scheier, and Weintraub (1989) that consisted of 15 scales, each having a specific conceptual focus, with 4 items per scale. The Brief COPE has 14 scales, with two items each, measured on a four-point Likert scale ranging from 0 (*I haven't been doing this at all*) to 4 (*I've been doing this a lot*). There is no overall score for this measure, neither can a dominant coping style for a given person be generated. However, this measure provides information on strategies often employed to deal with stress associated with caregiving. Example of an item on the scale is “I've been trying to find comfort in my religion or spiritual beliefs”. According to Carver (1997), researchers can select scales that are of highest interest in their samples, rather than using the measure in an all-or-none manner. Carver (1997) reported the Cronbach's alpha for each scale as follows: Active Coping,  $\alpha = .68$ ; Planning,  $\alpha = .73$ ; Positive Refraining,  $\alpha = .64$ ; Acceptance,  $\alpha = .57$ ; Humour,  $\alpha = .73$ ; Religion,  $\alpha = .82$ ; Using Emotional Support,  $\alpha = .71$ ; Using Instrumental Support,  $\alpha = .64$ ; Self-Distraction,  $\alpha = .71$ ; Denial,  $\alpha = .54$ ; Venting,  $\alpha = .50$ ; Substance Use,  $\alpha = .90$ ; Behavioural Disengagement,  $\alpha = .65$ ; Self-Blame,  $\alpha = .69$ . Nonetheless, only seven (7) out of the 14 subscales were used in the present study. Cronbach's alpha recorded for each of the subscales used for 280 respondents are as follows; Active Coping,  $\alpha = .80$ ; Acceptance,  $\alpha = .82$ ; Religion  $\alpha = .87$ ; Emotional Support  $\alpha = .83$ ; Denial  $\alpha = .79$ ; Self-Blame  $\alpha = .90$ ; Substance Use  $\alpha = .97$ .

### **3.8 Research Procedure**

Data collection commenced after ethical clearance and official letters introducing the researcher as a student of the University of Ghana Psychology Department were obtained and presented at study sites. A semi-structured interview guide developed by the researcher upon consultation with supervisors, were piloted together with the scales used for the study in a similar

setting (Pantang hospital). This was to assess feasibility and appropriateness of the test materials within the Ghanaian situation before the actual study in the Eastern Region.

### **3.8.1 The Pilot Study**

Individual interviews were conducted with three (3) professionals and three (3) family caregivers by the researcher. The goal was to assess respondents' understanding of the guide and also know if the guide was able to gather the appropriate data. Likewise, the quantitative measures were piloted on 40 family caregivers. Both aspects of the pilot took place after permission was granted by the institution, and consent given by the respondents. Community family caregivers were engaged at the psychological Out Patient Department (O.P.D), as they accompanied their relatives with mental illness for reviews. Questionnaires were administered as they awaited their turn to consulting rooms, laboratory, pharmacy, injection rooms, recovery, and the account section for payments, while ensuring privacy. Institutional family caregivers were engaged at the hospital's assessment unit and admission wards 7 and 9. Details of reliability for the various tests were; KCSS  $\alpha = .85$ , CWBS  $\alpha = .85$ , Affiliate stigma scale  $\alpha = .93$ , and that of the 14 subscales scales of the Brief COPE were; Active Coping,  $\alpha = .80$ ; Planning,  $\alpha = .43$ ; Positive Refraining,  $\alpha = .14$ ; Acceptance,  $\alpha = .86$ ; Humour,  $\alpha = .91$ ; Religion,  $\alpha = .81$ ; Using Emotional Support,  $\alpha = .89$ ; Using Instrumental Support,  $\alpha = .87$ ; Self-Distraction,  $\alpha = .92$ ; Denial,  $\alpha = .84$ ; Venting,  $\alpha = .47$ ; Substance Use,  $\alpha = .97$ ; Behavioural Disengagement,  $\alpha = .89$ ; Self-Blame,  $\alpha = .96$ . Eventually, seven (7) out of the 14 sub-scales of the Brief COPE (i.e. Active Coping, Acceptance, Religion, Emotional Support, Denial, Substance Use, and Self-Blame), were selected and used in the main study because of their relevance to study.

### **3.8.2 The Main Study**

Following pilot study and site approval by the Eastern Regional Director of Health Services, informed consent was sought from individuals who met the inclusion criteria of the study, and also understood the study itself and the content of the written consent. Respondents were informed about their right to decline or participate by appending their initials and signature or thumb print on a written consent form. One-on-one interviews were conducted with 20 purposively selected respondents (10 professionals and 10 family caregivers), with the aid of the piloted interview guide to explore their experience in community-based mental health care. Audio recordings of interviews were permitted by respondents, which lasted between 20 and 30 minutes. Interviews were conducted in a secluded office situated in the mental health unit of the Eastern Regional hospital to avoid interruptions, and also ensure privacy. Concurrently, questionnaires were administered to 280 purposively sampled family caregivers to help identify differences in stress, affiliate stigma, wellbeing, and coping strategies of the community and institutional family caregiver groups, as well as examine the impact of caregiver stress and affiliate stigma on caregiver wellbeing, and also investigate the relationship between coping strategies and caregiver wellbeing. There were a hundred and forty (140) respondents in each group of family caregivers. Data was collected during reviews at the mental health unit and home visits. Each questionnaire was completed in approximately 20 minutes. A research assistant was trained to help with data collection, which lasted for two (2) months.

### **3.9 Ethical Consideration**

The researcher sought ethical clearance from the Ethics Committee for Humanities, University of Ghana. According to Creswell (2007), respondents have a right to; voluntary participation, informed consent, protection from harm, anonymity, confidentiality, dignity and self-respect. These were ensured to guarantee the genuineness of this study. Potential

respondents were not coerced in any way. Research procedures and possible risks (tiredness from completing questionnaires) were clearly communicated to individuals to consent or decline participation. Respondents were not exposed to situations that could have risked them to harm, be it physical and or psychological as suggested by William (2006). Recognisable information was neither recorded in questionnaires nor appeared anywhere in the study. Private information, audio and transcribed materials will only be shared with a third party after respondents duly permit. These were enforced to ensure anonymity and confidentiality, and also safeguard respondents' dignity and respect as noted by Fouka and Mantzorou (2011).

### **3.10 Method of Analysis**

Distinctive techniques were used to analyse data obtained from the qualitative and quantitative aspects of this study. Thus, transcribed data from interviews and data obtained from questionnaires were examined differently. A description of the various techniques used are as follows:

#### **3.10.1 Analysis of Qualitative Data**

Interpretative phenomenological analysis (IPA) was utilised in the analyses of transcribed interview data (Smith & Osborn, 2003). This approach guided the researcher to make sense of caregivers' attempt in making sense of their experiences with community-based mental health care (CBMH), recognising them as sense-making organisms, rather than giving objective accounts recommended by previous hypothetical assumptions (Smith & Osborn, 2015). Initial coding of transcribed responses from caregivers was based on the researcher's concentration on identified patterns of caregivers' views on the benefits of CBMH; challenges with CBMH; thoughts on improving CBMH; challenges with INST; the model (CBMH and INST) associated with more stress; caregivers' thoughts on shift from INST to CBMH; preference of model for mental health care; effect of CBMH on caregiver finances, career; activities of daily living; and

wellbeing; society's attitude towards caregivers of persons with mental illness; effect of society's attitude towards caregivers of persons with mental illness, and coping strategies.

The next level of analysis concentrated on understandings derived from explanations and denotations made of respondents' experiences. Similarities and disparities in the codes generated were assessed throughout the responses to generate clusters of ideas. Quotes, codes and interpretations compiled by the researcher were reviewed by two supervisors to ascertain their extents of agreement and discrepancy. There were several encounters between the researcher and supervisors in modifying codes and themes generated until a consensus was reached. This thorough examination of caregivers' personal accounts was followed by a presentation and discussion of broad themes identified, which was paired with the researcher's interpretation (Pietkiewicz & Smith, 2012).

### **3.10.2 Analysis of Quantitative Data**

The Statistical Package for Social Sciences (SPSS) version 23.0 aided the analyses of the quantitative data. Specifically, a one-way Multivariate Analysis of Covariance (MANCOVA) was used to assess differences between community and institutional family caregivers in stress, affiliate stigma, and wellbeing, as well as differences in coping strategies used. Also, Hierarchical Multiple Regression analysis was used to examine the impact of caregiver stress and affiliate stigma on caregiver wellbeing, and the relationship between coping strategies and caregiver wellbeing.

### **3.11 Trustworthiness of Qualitative Findings**

To certify the trustworthiness of the findings of the qualitative aspect of the present study, the recommended strategies by Shenton (2004) were observed. Firstly, to ensure credibility (internal validity), individuals were offered an equal chance to decline participation

prior to interviews. Thus, respondents who were interviewed agreed to participate on their own accord. It is believed that since they chose to participate in the study, they were more likely to furnish the researcher with honest and detailed lived experiences in community-based mental health care. Besides, questions were rephrased during interviews to facilitate data collection. Moreover, there were several debriefing sessions with third party (supervisors) and the use of peer checking during the analysis process, which helped to shape the study and also manage flaws. Nonetheless, the findings of the present study were to a large extent confirmed by existing literature.

Similarly, transferability or generalisation was safeguarded by ensuring that the context and the sample used to study caregiver experiences was an example of the larger group of caregivers of persons with mental illness. Also, a comprehensive depiction of the phenomenon explored was provided to allow a comparison with previous studies conducted in similar situations. The criteria used to select respondents for data collection, the number of respondents, methods for data collection, the number and duration of data collection sessions, including the period over which information was gathered were noted. On the other hand, a repetition of the present study in a similar fashion is likely to yield similar outcomes, considering the thorough description of its design, which ensures dependability (reliability). Furthermore, issues with confirmable (objective) were tackled by the use of the Interpretative Phenomenological Analysis (IPA) which guided the researcher to make sense of the meanings caregivers attach to their experiences in community-based mental health care, instead of presenting recommended accounts by previous hypothetical assumptions (Smith & Osborn, 2015). Additionally, limitations of methods used for the present study and prospective consequences were duly noted.

## CHAPTER FOUR

### RESULTS

#### 4.1 Introduction

The present study explored the experiences of professionals and family caregivers in community-based mental health care settings in the Eastern Region of Ghana. To achieve a deeper understanding of caregiver experiences, caregiver stress, affiliate stigma, wellbeing, and coping strategies were investigated. Also, the difference between community and institutional family caregivers on these variables was assessed. Again, the impact of caregiver stress and affiliate stigma on caregiver wellbeing was assessed, and the relationship between coping strategies and family caregiver wellbeing also examined. This chapter presents findings based on research questions and formulated hypotheses in line with the objectives of this study. The qualitative findings precede the quantitative findings.

#### 4.2 Qualitative Results

Responses obtained from individual interviews with the aid of an interview guide were examined using Interpretative Phenomenological Analysis (IPA). These were captured under various themes. Details of the findings are presented below.

##### 4.2.1 Emerging Themes

In agreement with the study's objectives, the following research questions were asked:

1. What are the experiences of professionals and family caregivers offering community-based mental health care?
  - a. Specifically, the study aimed to explore benefits of CBMH; challenges with CBMH; thoughts on improving CBMH; challenges with INST; model associated with more stress; preference for INST and CBMH; thoughts on shift from INST to CBMH; effect of

CBMH on caregiver finances, career, activities of daily living and wellbeing; society's attitude towards caregivers of persons with mental illness; and the effect of society's attitude towards caregivers of persons with mental illness.

2. What are the coping strategies employed by professionals and family caregivers?

Quotations from interviews in line with emerging themes are labelled with identifiers

(Respondent's Id and type of caregiver) to conceal professional and family caregiver identity and safeguard confidentiality.

#### **4.2.2.1 Benefits of Community-Based Mental Health Care**

Generally, CBMH was deemed useful for the care of persons with mental illness by all professionals, and 7 family caregivers based on their appreciated benefits with the model.

Among the benefits of CBMH counted by professionals and family caregivers' accounts were:

provides social support from family; provides avenue for the expression of challenges; convenience of care delivery; builds trust from one-on-one contact with patients; facilitates integration and reduces stigma; provides avenue for education which reduces stigma and discrimination; enhances patients' activity level; builds confidence in patients through acceptance and sense of belonging; reduce the length of patients' stay in hospital; and cost effective.

***Provides social support from family:*** Respondents perceived the home as an ideal context for care. They highlighted that patients were surrounded with familiar people, who were able to keep up with patient's day to day activities. The continued presence of the patient at home was perceived to aid in the monitoring of the patient's recovery progress and also serve as an avenue for caregivers to quickly notice changes in patient's condition for prompt attention:

These were explained to contribute to a satisfaction in both patients and their families:

My view about community-based mental health care is that for mental health patients, they are best cared for in their own home environment. With this, it involves the patient himself or herself and their relatives as well as the household. It is better to nurse patients in their own home environment than in the institution (Respondent 1, professional)

I think it's a good idea. At least once the patient is with you, you will be able to know day in and day out how he/she behaves, and even if something happens, you will be able to rush him/her to the centre (mental health facility) for care instead of rushing her through a long distance to other places for care (Respondent 13, family caregiver)

***Provides an avenue for the expression of challenges:*** CBMH was also perceived to afford opportunity for the expression of the challenges faced by the patient. This was explained by a professional to imply patients were able to effectively communicate issues and challenges bothering them during a one-on-one contact in the community than in the institutional setting. This is, in institutional settings, professionals have to attend to a number of patients at the same time, which relatively reduces the extent of one-on-one contact with patients, necessary to afford patients the opportunity to freely express their challenges.

With the community-based mental health care, I think it's very helpful. With this, you meet your patient one-on-one and they express their issues and challenges when you come around as compared to institutional care (Respondent 2, professional)

***Convenience of care delivery:*** Professionals (4) indicated that CBMH involved their reaching out to patients within communities, instead of the patients accessing care in institutions. Instances where patients did not show up for treatment in institutions due to financial and time constraints were avoided. Thus, the delivery of services within the patient's community

improved access to care and also provided an opportunity for interaction with the community.

These were also acknowledged by a few family caregivers:

Community -based mental health care, I think it is helpful because we are able to interact with our patients right within the community, and they are able to access care wherever they are (Respondent 8, professional)

Community -based health care is about taking care of the patient at home and then coming to the hospital periodically for medications for the patient  
(Respondent 14, family caregiver)

***Builds trust from one-on-one contact with patients:*** Some professionals emphasised that CBMH helps to build trust through individual contacts with patients in the community. Patients were thereby offered the opportunity to know their caregivers, which ultimately maintains privacy and confidentiality to enhance effective communication:

I see community-based care as a situation whereby the care people need is rendered in the community for them. I see that this type of care makes the people get to know the caregiver very well, and have confidence in them [caregivers] because they are close to people (Respondent 4, professional)

To me, when I visit patients one-on-one they are able to talk about their problems, especially financial challenges in relation to purchasing medication. They also confide in you and tell you more even about their personal problems as compared to the ward (institution) (Respondent 2, professional)

***Facilitates integration and reduces stigma:*** Professionals indicated that, CBMH offered patients and their families the opportunity to move freely within the community, which helped

them to relate with community members. Hence, society was said to become previewed to changes in patients' condition. This helped to reduce stigma and facilitated integration upon recovery:

Community -based mental health care is a good approach in the practice of mental health care delivery. It helps the individual or the mentally ill patient to integrate well into the community in which he or she lives. It helps the family members of the mentally ill to be able to move freely within the community which in a way reduces the stigma attached to mental illness (Respondent 6, professional)

It's very helpful because it helps the patients to relate with their family members and the community which helps to integrate them back to the society when they are well (Respondent 5, professional)

***Provides an avenue for education which reduces stigma and discrimination:*** Again, some professionals explained that, relatives become knowledgeable in their patients' condition, as they participated in their care, and also through the activities of professionals within the community (e.g. Health education). This knowledge was perceived to transcend to the larger community to curb the stigma and discrimination attached to mental illness:

It is helpful, as I said very, very helpful. It reduces stigma and discrimination when they are nursed in their own home environment and their relatives also get to know about their condition (Respondent 1, professional)

It helps to integrate the relatives in the care of the patients so they know what is going on in the life of the patient. It also reduces stigma because within the community, everybody

knows a little bit about what is going on in patients' lives and are able to sympathise with relatives and patients themselves (Respondent 7, professional)

***Enhances patients' activity level:*** Regarding patient's movement, some caregivers (both professionals and family caregivers) registered their appreciation for the less restrictive environment offered by CBMH for the care of persons with mental illness. Caregivers stated that, patients did not feel restricted, and were presented with various opportunities to better their lives during their recovery and rehabilitation process:

Oh, it's helpful because patients in the community do not see themselves as restricted. They see themselves as they always live in the community, and get love and care from their family and friends within the community (Respondent 4, professional)

That [CBMH] is something like outpatient care. It is ok, because normally the patient has to live within a society and so getting him to a place where he doesn't mingle or interact with other people becomes difficult. For example, if his condition is ok, he must go to school or have a vocation, but keeping him in a place like a hospital or an institution will not give him the chance to do that. Besides, in Ghana we don't have all the facilities that could train them. Basically, they have to grow up, have a trade and live a normal life. The family cannot be supporting them all the time because of a lot of factors. I believe that if more resources and structures are put up, patients can live in the community. It's better than the institutional based care (Respondent 11, family caregiver)

***Builds confidence in patients through acceptance and sense of belonging:*** Patients were perceived to be inspired through confidence which resulted from their feelings of acceptance and belongingness within their communities. Both professionals and family caregivers could not have agreed much on this stance. Patients were perceived not to have

feelings of loneliness or dejection when they were cared for in their communities where the presence of familiar people was inevitable. This was found to avert feelings of dejection, often noted among patients while in institutions, which usually resulted in absconding tendencies:

It helps to embolden the individual, especially the mentally ill to see himself or herself as part of the community. These individuals have some form of acceptance within the community as everybody around sees them as part of the community and so do not discriminate against them (Respondent 6, professional)

Community-based mental health care is about our caring for people with mental illness in their communities so that the patient will feel being part of the community, and the community also seeing the patients as part of them. Thus, the care of patients is not only allotted to hospital, but also the society becomes part of patients' healing process (Respondent 10, professional)

***Reduce the length of patients' stay in hospital:*** CBMH was noted to reduce the duration for which patients had to remain in institutions until they had fully recovered. This is because CBMH offers opportunity for patients to continue with care in their communities with support from professionals. This was emphasised by a professional as stated:

It [CBMH] is helpful because it has come to reduce the length for which patients could stay in hospital in cases of admission (Respondent 9, professional)

***Cost effective:*** Family caregivers perceived CBMH to reduce stress. This was however in line with the model's cost effectiveness. Family caregivers had less travel to make to institutions for appointments or visits which suggested less transport cost, and also spent less money in caring for their relatives with mental illness at home:

Oh, it reduces our financial stress (Respondent 13, family caregiver)

Well, at the moment it's helpful because I don't have to travel frequently as I would have done if she [patient] was on admission (Respondent 17, family caregiver)

To a largely extent, the perceived benefits of CBMH were shared by both professionals and family caregivers. In sum, CBMH provides an avenue for the expression of challenges; the model is convenient for care delivery; builds trust from one-on-one contact with patients; facilitates integration and reduces stigma; provides avenue for education which reduces stigma and discrimination; enhances patients' activity level; builds confidence in patients through acceptance and sense of belonging; reduce the length of patients' stay in hospital; and is cost effective.

#### **4.2.2.2 Challenges with Community-Based Mental Health Care**

Despite the enumerated benefits with CBMH of the present study, professionals and family caregivers expressed some challenges with the model, touching on four (4) distinct domains as: resources and vital structures constraint; risk associated with caregiving; burden or stress associated with caregiving; stigma and discrimination. Each domain was explained by caregivers, out of which various sub-themes were formed, as presented:

##### **1. Resources and Vital Structures Constraint**

Specifically, professionals expressed their discontent with the lack of vital structures, inadequate human resources, and rarity of support for mental health services. Professionals' expectations for certain situations were additionally registered:

***Lack of vital structures:*** Professionals registered their concerns in line with scarcity of logistics to enhance community care. It was noted that CBMH needed to be more organised such that, there will be essential facilities within the community. Examples were cited to include

clubhouses, rehabilitation centres, and occupational therapy departments. Also, the lack of a means of transport for community activities was revealed as a major challenge to professionals. All the aforementioned were deemed crucial to enhance mental health service delivery in the community:

... There is lack of logistics for community work such as thermometer, sphygmomanometer among others that are used on the ward [institution] to check vital signs. Hence, staff only talk to patients and relatives during home visits e.g. if they are not taking their drugs... (Respondent 7, professional)

... It [CBMH] should be organised such that we have club houses, and even occupational therapy departments so that the patients can have all these therapies (Respondent 1, professional)

***Inadequate human resources:*** Professionals indicated that the number of professionals working in the community was inadequate. This situation puts a lot of pressure on the few professionals delivering care, considering the large population served. Also, professionals desired for emergency teams to be put in place to help attend to distress calls more effectively. However, the realisation of this was anticipated to be dependent on an adequate human resource capacity:

... We do not have much people on the ground at the primary level to integrate mental health services into the general health system... (Respondent 8, professional)

... We should have an emergency team to be attending to patients when we [professionals] are called to attend to patients at home. The absence of this brings about a lot of challenges... (Respondent 1, professional)

*Rarity of support for mental health services:* CBMH requires professionals taking care to the doorstep of patients, their families and the community at large unlike institutional care. However, professionals noted that there was no provision for transport, neither was reimbursement for the cost of transport and other expenses in relation to service delivery in the community:

... At the moment, there is no support for mental health services, so there are some communities that you have to bare the transport cost... (Respondent 1, professional)

... There is no support for transport for home visits and the rest. You have to use your own pocket money or the little you get from your salary, so it really affects my personal income (Respondent 9, professional)

## **2. Risk Associated with Caregiving**

Professionals' description of risk related to their practice within the community was revealed to have largely emanated from the patient's home environment. This was understood to be alarming per the emotions that accompanied their accounts:

*Unsafe patient's home environment:* Professionals disclosed some awful experiences with dogs and patients during home visits. Some recounted histories of dog bites and sexual harassment by patients without getting help from people due to their fear of patients:

Hmm, with community-based care, at times you wouldn't know if there is a dog around and may get bitten. I have not had a dog bite before, but I have seen it happen to someone. So, if we go to a house and see dogs around, we are sometimes advised not to enter... (Respondent 2, professional)

... Sometimes you can go to a house and patient will harass you sexually. There could be others in the house, but they may not be willing to help because they might be afraid of the patient (Respondent 5, professional)

### 3. Burden or Stress Associated with Caregiving

Seven sub-themes emerged under this domain of challenges with CBMH. Professionals were particularly concerned with financial stress and difficulty locating patients' homes during home visits. On the other hand, family caregivers were much bothered with noncompliance; inappropriate behaviour; prolonged contact with an indifferent relative; time constraints and inability to work:

**Financial stress:** Although few (2) family caregivers touched on financial constraints, this problem ran through every (10) professionals' account on experience with CBMH. This obviously made professionals the most affected. Professionals narrated their personal loss in line with the cost of transport, communication and assistance given to patients who could not afford treatment:

There are a lot of challenges that comes with it. It involves money, you have to spend on transport moving up and down (Respondent 10, professional)

I cook every day because of him [patient], and you should see the quantity of food I give him [plenty] but it doesn't really bother me much. He likes fufu [local dish] too, so for that he will pound (Respondent 16, family caregiver)

**Difficulty locating patients' homes during home visits:** Moreover, some professionals narrated the difficulties associated with locating patients' homes during visits. This was linked with the poor landmark system and roads in some localities, long distances covered to reach

patients, unfavourable weather conditions (scorching sun or rain), and the refusal of some community members to offer assistance in directing professionals during home tracing. This refusal was perceived to be based on fear that persons (patients) being sought for could be in trouble:

Yes, with regards to the landmark system in Ghana, locating a particular individual home is a challenge. Also, there is a low level of education of people within the community with regard to mental health. If the people around do not understand mental health issues and how to identify somebody who is mentally ill, it becomes a challenge when they are living with one. To me, transport cost, and inappropriate direction given while tracing patients is a challenge. Sometimes, people think you are going to harm someone, or to imprison or you have a case with the people being traced, so you find it difficult getting direction to patients' homes (Respondent 6, professional)

One of the challenges is poor roads: Some communities in Koforidua [Eastern Regional capital] for instance Betom have poor roads linking patients' houses. Some are not accessible, and you may have to walk far distances to some houses... There is a lack of financial support too. You know, because we don't have cars, nurses use their own money for transport, which means they cannot go and attend to patients if they don't have money. With community-based care, sometimes some of our patients leave for work very early and so if you don't meet them at homes in the morning, you may have to go again in the evening unlike institutional care where you get to finish everything during a particular shift... (Respondent 7, professional)

**Noncompliance:** Account was given by a family caregiver on the difficulty associated with supervising patients' medication intake at home. A relapse was said to trigger following refusals, as patients become restless, and in some cases roamed indiscriminately:

The problem is basically with medication. Sometimes they don't take them as per the time. They are sometimes restless too, which gets them loitering about. Sometimes you cannot get them for maybe 2 to 3 days or a week for them to take the medication, and that's the biggest problem. Besides, people make ridicule of them because of the stigma, although there is awareness that the patients are like any of us and it's only a disease (Respondent 11, family caregiver)

***Inappropriate behaviour:*** Family caregivers reported instances where patients exhibited behaviours that were not acceptable. These behaviours were revealed to have led to their abandonment, even by some love ones. Family caregivers also recounted being embarrassed and uncomfortable with such behaviours, especially when they had visitors. Respondents related the loss of respect for persons with mental illness to their inappropriate behaviour:

... The way they behave, my sister for instance, has a husband, but because of her condition he has abandoned her, so day in and day out she cries that she wants to go to her husband and all this stuff... My old girl [mother] too is old, so sometimes it puts stress on her... (Respondent 13, family caregiver)

Yes, the patient being at home sometimes makes it feel uncomfortable when you have visitors around because depending on the intensity of their condition, they can sometimes scare people away from home (Respondent 14, family caregiver)

***Prolonged contact with an indifferent relative:*** Some family caregivers were particularly bothered by the idea of living with individuals who refused or could not respond or even interact with others at home, yet were able to communicate effectively with people when they went out:

I am currently alone with him at home, he does not talk and wouldn't laugh even if something is funny. He is always serious (Respondent 16, family caregiver)

I do not see living with my brother at home helpful, but there is nothing I can do. Here is someone who even refuses to watch television. He doesn't respond when you talk to him at home. I can't explain because he communicates and laughs with people when he goes out (Respondent 14, family caregiver)

***Time constraints and inability to work:*** Family caregivers described their plight in line with time while caring for their relatives with mental illness at home. Again family members who had to balance work with caregiving found it challenging. Some noted that time for work was curtailed as a result of caring for a mentally ill relative. Similarly, others registered displeasure with inability to work at all. Obviously, this possessed a great deal of worry to family caregivers who had to fend for their families:

We go through a lot of challenges. Sometimes we wake up early to prepare for the farm, but we may have to take care of our mother first before we leave the house, and that is a big challenge for us. We leave her in the care of my brother's wife [caretaker] when going to the farm, but she refuses to communicate with her caretaker (Respondent 19, family caregiver)

My daughter's presence at home brings a little problem. Her father is dead, and living with my mother is challenging. Her behaviour at home does not bring happiness, and it torments me greatly to the extent that I can't do any work. I am always by her side to control her (Respondent 18, family caregiver)

#### **4. Stigma and Discrimination**

Accounts on stigma and discrimination were given in line with the source and how stigma was maintained.

**Poor knowledge in mental health:** Although stigma attached to mental illness was noted to be directed at sufferers, it was recounted to have extended to family caregivers, and even professionals sometimes. Besides, stigma was identified to have existed in health care institutions, and usually perpetrated by some health professionals who were not in the field of mental health. Thus, stigma did not only persist in the community. Professionals attributed stigma attached to mental illness to poor public knowledge in mental health, the confined nature of institutional mental health care, and the wearing of uniforms by mental health professionals. Uniforms were recounted to have contributed to the stigma, as some community members become curious about professionals' regular visits to patients' homes. Consequently, some patients refused professional visits for fear of people getting to know about their condition, which often followed with stigma and discrimination:

... About the stigma, even our own colleagues (nurses) sometimes call us “abodam nurses” [mad nurses] and all that, even though they have some education about mental health. I think those [mental health professionals] on the ward [institution] are more stigmatised than professionals working in the community. This is because professionals working in institutions are confined, and also wear uniforms, unlike those working in the community who wear mufti [civil attire]... (Respondent 3, professional)

**Gossip from the community:** On the other hand, a family caregiver associated stigma and discrimination attached to mental illness with misconceptions that are usually powered by community gossips:

Hmm, my daughter doesn't want anyone to know she has a mental condition, but our area is full of gossips (Respondent 17, family caregiver)

All told, the challenges associated with CBMH were more of structural and resource deficit origin for professionals (lack of logistics, inadequate human resources and rarity of support for mental health services; financial stress; difficulty locating patients' homes during home visits; and unsafe patient's home environment). Then again, inadequate skills to manage persons with mental illness was basically the case for family caregivers who were challenged with patients' inappropriate behaviour; prolonged contact with an indifferent relative; treatment noncompliance; time constraints and inability to work. Yet, the stigma attached to mental illness, although directed at sufferers, extended to professionals and family caregivers alike. Relatively, the findings of the present study demonstrate a much negative experience in CBMH for professionals, as compared to family caregivers. The circumstances described, provides a vivid picture of caregiver stress and affiliate stigma.

#### **4.2.2.3 Thoughts on improving Community-Based Mental Health Care**

Successively, caregivers shared various ideas for improving CBMH. These ideas were targeted at resolving identified challenges with the model. Provision of needed resources; stakeholder engagement for assistance; capacity building and professional assistance; reduction in stigma and discrimination; caregiver welfare; and support from government were sub-themes that emerged from caregivers' accounts on improving CBMH.

***Provision of Needed Resources:*** Caregivers (8), mostly professionals (7) called for the provision of adequate logistics, funds and vital structures. According to them, there should be enough structures within the community to support persons with mental illness, and to augment recovery. Examples of community structures were cited to include: club houses (a community centre that helps to instil confidence in persons with mental illness and present prospects for attaining full potential), occupational therapy departments and rehabilitation centres. More importantly, professionals stressed on the need for an increased human resource capacity to

facilitate community-based care, and the provision of incentives to motivate community staff.

Again, a proposal for adequate means of transport to aid movement while delivering community services could not be overemphasised:

I think we have to get more facilities within the community itself. There should be some kind of incentives for mental health professionals, especially for those who render services in the community. Cars and motor bikes or bicycles for places where cars may not be able to go should be provided. In addition, it will be helpful to offer professionals some money for water, food, etc., even though we [professionals] have our own money for food (Respondent 4, professional)

To be honest, I don't know, but if more of your services can be provided at the community level, it will be ok since the patients are not supposed to be in the hospital for long. There should be some community structures to help take care of patients when they are at home, even temporarily (Respondent 13, family caregiver)

***Stakeholder Engagement for Assistance:*** A professional suggested the need to collaborate with stakeholders. Mention was made of Non-Governmental Organisations that are famous for assisting with the provision of medications, transportation, logistics and other forms of support that enhanced mental health service delivery:

We should get some NGOs to help finance community care. That is if they can provide us with medications, logistics and means of transport. Secondly, there should be compensation for professionals who go to take care of patients within the community and for instance get hurt by the patients. At least their hospital bills should be catered for in such instances (Respondent 7, professional)

***Capacity Building and Professional Assistance:*** Majority (6) of family caregivers called for professional backing to facilitate their role in patients' care. Clearly, family caregivers admitted their limitations in terms of basic skills and adequate knowledge to afford optimum guidance to their relatives with mental illness that guaranteed recovery. This request was in line with telephone reminders from professionals 'prior to appointments, home visits to track patient's progress, and continuous counselling for patients and relatives:

I can't really tell, but when the patient is at home it doesn't help. This is because he even refuses medication, but in the hospital, maybe they have a way of communicating or means to administer these drugs (Respondent 12, family caregiver)

Sometimes we [family caregivers] forget patients' appointments to the hospital for reviews, so if it will be possible I will suggest telephoning reminders to prompt us about review dates so we can come. This will keep us on our toes. I also don't know if we have gotten to the stage where professionals could visit us frequently at home to find out how things are going, maybe we haven't gotten there yet, but I believe that will be more helpful in a way (Respondent 15, family caregiver)

***Reduction in Stigma and Discrimination:*** A reduction in stigma and discrimination was perceived crucial for improving CBMH. To achieve this aim, the need for professionals to conceal their identity during home visits, and the intensification of mental health education was highlighted. The wearing of uniforms by professionals to visit patients' homes was noted to even worsen the situations. This is because, community members probe to ascertain the kind of condition that necessitates regular professional visits. As a result, community-based mental health professionals try to conceal their identity during home visits by wearing descent civilian clothes instead of uniforms to halt any stigma generated as such:

Because of the stigma they don't want us [professionals] to visit sometimes so I think wearing mufti [any descent attire apart from uniform] would improve community-based care than uniforms... (Respondent 2, professional)

Moreover, the need for education was stressed by professionals and family caregivers. This was considered to aid the reduction of stigma and discrimination, and also deemed to eventually improve CBMH. Seemingly, there was limited understanding of mental health and mental illness among the general populace. An emphasis on the need for family caregivers to be empowered to identify and effectively assume responsibility for caring could not be overstressed.

I think we have to do more education where ever we can get people. This is because they are not aware of the things we teach (Respondent 3, professional)

To me community-based care can be improved if family caregivers come to understand they have a responsibility of taking care of their relatives who break down with this condition, regardless of the financial difficulties. Community care can also be improved if medications are provided (Respondent 20, family caregiver)

**Caregiver Welfare:** This was noted by some professionals. A suggestion for the provision of diverse avenues for career progression, and stipulations in Ghana's mental health act (act 846 of 2012) which will efficiently address the concerns of professionals in line with motivation and occupational hazards was made. Concerns with safety for mental health professionals was equally deemed important by family caregivers:

What I want us to talk about is the mental health act focusing only the patients, only the patients, only the patients. I think something should be done for the nurses as well (Respondent 7, professional)

Oh, I believe I've said all I wanted to. My only concern is for the government to pay attention to you [mental health professionals] since your work is very risky (Respondent 20, family caregiver)

***Support from Government:*** A call for governmental assistance was made by both professionals and family caregivers as a means to enhance CBMH. This was in anticipation of governmental investment in mental health, and policies for improvement. Specifically, professionals proposed for the need for government to adequately invest in mental health. This was seen as a means to acquire needed resources to improve mental health care:

I think the government should invest more in community-based care. We need halfway homes, rehabilitation centres and other centres where the patients can go to relax or to have therapy. But if the government does not support these areas, the work we are doing cannot be fruitful. Most of the patients do not have work to do when they go home (after discharge). With the half way homes and occupational centres, they could go and learn a trade, relax and even have recreational activities there. I think the government should look at it from this angle, and adequately invest in community-based care so that patients can benefit from it more instead of the institutions (Respondent 10, professional)

Similarly, family caregivers anticipated an effective control of illicit drug abuse, which was perceived to have an impact on individuals who may be ignorant of the potential negative effects of such drugs. Again, a plea for the inclusion of mental health services in the national health insurance scheme (NHIS) through a policy with governmental backing was also made:

I believe there should be more education and more awareness of mental health. I think the government as an institution should also check on drug abuse, especially in the youth of

today because a lot of drugs are consumed without people knowing their impact on them.

Society as a whole should be aware (Respondent 11, family caregiver)

My problem is, my daughter is sick and cannot work now, but has insurance, so why can't her insurance cover her mental health care as it does when she is physically ill, and rather creating problems for my family (Respondent 18, family caregiver)

Basically, there was agreement on caregivers' thoughts for the improvement of CBMH. The provision of needed resources; stakeholder engagement for assistance; capacity building and professional assistance to family caregivers; reduction in stigma and discrimination; caregiver welfare; and Support from the government were approaches considered important.

#### **4.2.2.4 Challenges with Institutional Mental Health Care**

Equally, it was deemed fit to ascertain caregivers' difficulties with institutional mental health care. Impediments gathered by the present study in line with INST have been reported under six (6) sub-themes (confinement, aggression, abandonment by families, resource and infrastructural deficits, high cost, and accumulation of deficit symptoms). These are accompanied with illustration from caregivers' accounts.

***Confinement:*** According to professionals and family caregivers, when patients are cared for in an enclosed hospital setting where activities are often routine, it leads to boredom. Apparently, there are limited facilities which does not facilitate patients' recovery or rehabilitation. Patients' freedom was said to be deprived, all of which were perceived to communicate a feeling of imprisonment in patients:

What I have realised with institutional mental health care is that, patients do not have the freedom to move about, engage in their businesses and do something for themselves. In a

situation where there is no occupational therapy, the patients become ideal, which leads to boredom, as patients are always indoors. Besides the activities they do are recycling (routine), whereas there are lots of activities for them to do when they are in the community, including going to church (Respondent 10, professional)

In the first place it has to do with their psychology [thoughts], they believe they are in prison because they are restricted while in institutions (Respondent 11, family caregiver)

**Aggression:** The tendency of professionals getting hurt by aggressive patients, especially in institutional settings was reported by some professionals. However, the present study established that the need for vigilance was upheld by mental health professionals as a safety measure:

Especially, when the patient is very aggressive and you are not careful you might be hurt. Patients need special care so you have to be very vigilant with them. At times, you may be attending to two or more patients, and if you don't take care a patient might end up hurting. I think we need more professionals to do that. Aggressive patients are usually brought to the institution, so you do not find them in the community as you will in the institution (Respondent 2, professional)

There is aggression in institutional care, and professionals normally get hurt (Respondent 3, professional)

**Abandonment by Families:** The practice of family members leaving their mentally ill relatives in institutional settings without a follow up was indicated by caregivers. For instance, an account from a professional revealed that some family caregivers were misconceived that the

care of persons with mental illness was only appropriate in institutions, regardless of prevailing conditions in institutional settings:

When a person is brought to the hospital for admission, maybe first and second, by the third time, the family sees the hospital as a place where they can come and dump their patient at any time and also request for their discharge at any time. This later leads to families abandoning their patients all the time. They begin to see leaving the patient in the hospital as ideal (Respondent 6, professional)

People have different ways of seeing things, hence some will abandon their patients in the institution, but if you have empathy you will even wish the patient is home for you to ensure he takes his medication and other things yourself. The challenge with institutional care is that you may have to visit patients on a regular basis once they are admitted (Respondent 15, family caregiver)

***Resource and Infrastructural deficits:*** Again, there were problems with resource and infrastructural deficits in institutional mental health care. Both professionals and family caregivers noted problems with limited space, fewer admission beds, inadequate or unavailability of needed psychotropic medications, low staff strength, absence of seclusion rooms, and other tools needed to assist with the management of aggression which is peculiar to INST. Consequently, patients whose condition required observation and management in institutional settings did not have access to the care they needed as verbalised by professionals:

Speaking for the facility where I work, there is a lack of infrastructure: it is too small, for instance, there is only one ward for the female patients, no seclusion room, and the beds for admission (20) are inadequate. As a result, sometimes we have a lot of patients

coming in who need admission but because of the lack of infrastructure we have to refer. Besides some relatives are not supportive, both financially and emotionally. Some don't even visit at all when they bring their patients for admission and also don't provide financial needs. However, when the patient is within the community, relatives will know what is going on and appreciate the need to provide for them. (Respondent 7, professional)

Sometimes, we don't always have the facilities to take care of our patients. For example, in my unit there is no seclusion room. Apart from that, sometimes you may not have any of the needed medications or the tools to deal with aggression. There may be the need to restrain a patient after sedation, but there is nothing to do that (Respondent 9, professional)

***Accumulation of Deficit Symptoms:*** Due to limited space in institutional settings, as identified by the present study, patients do not have the luxury of being treated in different settings based on their conditions and also in smaller groups, which results in some patients adopting negative behaviours from others:

Learning other behaviours from inmates. Fear of being attacked by aggressive inmates (Respondent 20, family caregiver)

One thing lacking with institutional care is the lack of facilities. The space is also not enough for the wards. Again, there are times where some patients' situation might be more serious than others and it happens that they are all seem to be in the same place which is not the best (Respondent 14, family caregiver)

**High Cost:** In terms of cost, family caregivers reported the expensive nature of institutional care. This was in line with admission charges, medications, and transport for frequent visits to institutions when mentally ill relatives are managed in institutions:

... Patients and their relatives have to foot their own bills (i.e. Cost of medications, admission, and other expenses) which they are sometimes unable to afford. Hence, some end up on the street since there is no support from the government (Respondent 3, professional)

I will not have any problem with institutional care if only the government takes up admission charges, otherwise my patient should be home for me to share the little food I have with since I cannot afford admission charges (Respondent 12, family caregiver)

To some extent, the challenges associated with INST (i.e. Confinement, aggression, abandonment by families, resource and infrastructural deficits, high cost, accumulation of deficit symptoms), affected both professionals and family caregivers. For professionals, challenges with institutional care were again more of a resource deficit inclined, whereas family caregivers found the high cost of INST particularly challenging.

#### **4.2.2.5 Model Associated With More Stress**

Having identified challenges peculiar to each of the two (2) models of mental health care in Ghana (CBMH and INST), it was inquired from caregivers which of the models was associated with more stress. The present study found CBMH more stressful, as evidenced by caregivers' ratings (12 out of 20 caregivers rated CBMH more stressful). However, professionals (7) found CBMH more stressful than family caregivers (5). Professionals' rating was based on the several movements and long distances covered while delivering services in the community; the cost of transport; multitasking; lack of capacity building within the community; and

treatment noncompliance. Conversely, there were 3 professionals who rated INST more stressful due to difficulty running a shift system, more workload and aggression:

Community-based care is more stressful because in this instance you will have to do home tracing, and visit patients one by one. There is a lot of walking, a lot of talking, a lot of education, and all these are very tedious unlike institutional care where patients will come to you, so the talking and walking are all reduced (Respondent 8, professional)

I prefer community, although it's stressful sometimes. Waking up early to go for home visit, walking, and sometimes your shoes, even gets thorn is very stressful (Respondent 5, professional)

Generally, more professionals (7) found CBMH more stressful than family caregivers (5).

Reasons accounting for this perception included several movements and long distances covered by professionals within the community; the cost of transport; multitasking; and lack of capacity building within the community.

#### **4.2.2.6 Preference for CBMH and INST**

Surprisingly, regardless of the challenges leading to caregiver stress and affiliate stigma identified with CBMH, caregivers largely preferred the model for the management of persons with mental illness to INST, as evidenced by ten (10) professionals and five (5) family caregivers opting for CBMH:

For now I'll prefer community because of the current situation of institutional care. One thing lacking with institutional care is the lack of facilities. The space is also not enough for the wards. Again, there are times where some patients' condition might be more

serious than others, but it happens that they are all managed in the same place which is not the best... (Respondent 14, family caregiver)

Evidently, professionals were noted to have an understanding of the benefits of CBMH, as well as its potential to enhance recovery. Thus, professionals' 100% vote for the model in spite of the current associated burden. However, although family caregivers had some understanding of the model's usefulness, their basic drive for choosing CBMH was based on convenience in terms of cost effective, less travel, and the calm nature of patients' condition. Conversely, family caregivers (5) who opted for INST considered their inability to effectively supervise patients at home:

I will choose institutional care, since he [patient] will take his medications here  
(Respondent 16, family caregiver)

Generally, CBMH was the preferred model for mental health care to caregivers (15) although the model was perceived not to be fully functional due to associated challenges.

#### **4.2.2.7 Thoughts on shift from Institutional to Community-Based Mental Health Care**

Three (3) themes were formed from caregivers' views on the shift. These were: Support for shift, albeit noted challenges; a need to maintain both models; and disapproval of shift.

***Support for Shift albeit noted Challenges:*** Eight (8) professionals and seven (7) family caregivers who formed the majority of caregivers (15) for the qualitative study were in total support for a shift from INST to CBMH. CBMH was however perceived not to be functioning as expected due to the lack of resources. Accounts from caregivers clearly demonstrated an unmet expectation of the models' implementation. According to caregivers, CBMH has potential

benefits, and perceived as a good approach to mental health care despite prevailing challenges. Again, caregivers' support for a shift was based on the benefits identified with CBMH, which included family involvement; reduced workload in facilities; increased education towards stigma reduction; least restrictive environment for patients' care; and prevention of maladaptive behaviour from other patients:

Yeah! It would have been very good for us to shift from institutional to community-based care if all the needed resources were provided (Respondent 1, professional)

Actually, I think it's a good idea, but the little challenge here is about stigmatisation. Some families take their patients home and ignore or refuse to take proper care of them because of their status. Although there might be few relatives who might still accept patients as their relative, majority will not be concerned. Looking at the current situation, I think community-based care is not in the best state (Respondent 14, family caregiver)

***A Need to Maintain Both Models:*** Nonetheless, few professionals (2) believed that, the care of persons with mental illness necessitated a combined model approach. To them, the two models served different purposes. For instance, aggressive patients may need to be hospitalised for observation and management to become stable before they could continue with treatment at home. Caregivers further noted the potential danger in managing aggressive patients at home, as well as the potential for patients hurting others in the community:

I think both are very important because sometimes the patients are very aggressive and need to be hospitalised, given medications for them to become stable before they are moved to the house. This is because you cannot manage such patients at home. An

aggressive patient may hurt someone. Well, we can manage the shift like that, but I think the two should be maintained (Respondent 2, professional)

***Disapproval of Shift:*** Only three (3) family caregivers advocated for INST instead of CBMH. To them, persons with mental illness needed to be managed in institutions. Reasons given for this stance were: persons with mental illness did not recover completely, there was much stress associated with managing patients at home, and some conditions were not suitable for community-based care:

No, no, no patients must be kept in the hospital because they are sick, just like I come to the hospital when I'm also sick. You see, for this their sickness they don't really recover completely (Respondent 12, family caregiver)

Community-based care might not favour some patients due to their condition. Some might attack and hit others with something to kill when they are aggressive among others, which may not be helpful. Professionals should also get some form of protection, since life is important (Respondent 20, family caregiver)

Conclusively, the majority of caregivers (8 professionals and 7 family caregivers) were in support for a shift from INST to CBMH despite existing challenges.

#### **4.2.2.8 Effect of CBMH on Caregiver**

There were noticeable differences between professionals and family caregivers on the effect of CBMH. Basically, the effect of CBMH on caregiver finance, career, activities of daily living and wellbeing was explored. Accounts were gathered under four (4) sub-themes, including the effect of CBMH on caregiver finances, career, daily activities, and wellbeing:

***Effect of CBMH on Caregiver Finances:*** There were more professionals (7) affected on finances than family caregivers (3). Professionals' challenge with cost was in line with transport, communication and assistance given to patients who could not purchase their medications or meet other needs. Yet, 5 family caregivers gave accounts of the cost effectiveness of CBMH:

Sometimes you have to foot your own bills to places, make calls and even get medications for patients, which affect my finances (Respondent 6, professional)

I do purchase medications and do other things for him, but I wouldn't say it affects my finances so much... (Respondent 15, family caregiver)

***Effect of CBMH on Caregiver Career:*** To a large extent, CBMH had no negative effect on professionals' career. Apparently, professionals (7) gave a report on passion for their field of work, fulfilment and respect derived from advocating for persons with mental illness. Thus, explaining for professionals' positive perception of CBMH on their career. Contrastingly, 7 family caregivers conferred a negative impact of CBMH on their career, and inability to engage in economic activities due to time constraints:

The effect on my career is in a positive way because of the respect people give you. You become like a "community champion", the guy who helped someone, which is a positive feeling (Respondent 10, professional)

In the absence of the caretaker, I don't have time to work... which results in me not being more efficient in my work place, which is not the best (Respondent 14, family caregiver)

***Effect of CBMH on Caregiver Daily Activities:*** Similarly, although CBMH was found to interrupt the activities of both professionals and family caregivers, family caregivers experienced more interruptions on their daily activities than professionals. This was evidenced by the

negative accounts given by 6 family caregivers, and 5 professionals. Yet, some caregivers indicated their ability to plan care effectively with their daily activities:

Community care does affect my daily activities because sometimes relatives will call you to complain about patients who are either refusing medications or have become aggressive when your husband is around. You may even have to rush there sometimes. Also, you may be called when you have closed from work and doing something at home, and you will have to leave it and go (Respondent 4, professional)

My daily activities are affected, for instance, I travelled to Accra some time ago only to be called that she was threatening someone with a knife so I aborted whatever I was doing and rushed back to Koforidua. I am the only one who can control her and that is why I can't go anywhere (Respondent 18, family caregiver)

***Effect of CBMH on Caregiver Wellbeing:*** Consequently, both professionals and family caregivers reported physical and psychological effects of caregiving on their wellbeing, although contrasting. Generally, family caregivers were more affected on wellbeing than professionals. Family caregivers reported an equal experience of the physical and psychological effect of CBMH, whereas professionals experienced more physical than psychological effects of CBMH on wellbeing. The Physical effects uncovered by the present study included: fatigue and physical strain; sleep deprivation; headaches; and worsening of caregiver's existing physical conditions such as glaucoma and hypertension. These were all explained to have resulted from the overwhelming work load in CBMH, unfavourable weather and work conditions (e.g. excessive walking by professionals in the discharge of services):

All these affect my well-being. Walking under this scorching sun alone is very stressful. Also, sometimes because you love your job and want to attend to your patients, you do not stay at home, even when you are not feeling well, especially when you have an appointment with them. So you don't really have time for yourself (Respondent 4, professional)

It affects my well-being because I can't even sleep, I think a lot when I go to bed (Respondent 18, family caregiver)

Moreover, psychological effects noted by the present study included fear of attacks by patients; stigma; and stress, which often resulted from excessive thinking about finances and patients' condition:

... It is scary, sometimes patients attack us when they are not taking their medications and become aggressive at home during our visit (Respondent 3, professional)

It does affect my well-being because, stress is not something you can measure physically, but it puts you into a lot of thinking (Respondent 11, family caregiver)

Overall, CBMH affected caregiver finances, career, daily activities and wellbeing, yet in opposing ways. The present study found a more negative effect of CBMH on the finances of professionals (7) than family caregivers (3). Thus, the cost effectiveness of CBMH was only in favour of family caregivers (5). Again, whereas CBMH negatively affected the career of 7 family caregivers, 7 professionals perceived a positive impact of CBMH on their career. Moreover, the daily activities of family caregivers (6) were more interrupted than it was for professionals (5) in CBMH. Finally, family caregivers (10) were affected on wellbeing than professionals (7). Also, whereas professionals (6) were more affected on their physical wellbeing than psychological

wellbeing (1), family caregivers (5) had an equal effect on their physical and psychological wellbeing.

#### **4.2.2.9 Society's Attitude towards Caregivers of Persons with Mental Illness**

Caregivers' perception of society's attitude towards them was basically stigma and discrimination.

***Stigma and Discrimination:*** This was noted as a major canker to caregivers. As explained, 9 professionals recounted instances where society related positively towards professionals, but stigmatised and discriminated against family caregivers and persons with mental illness. Yet, few caregivers noted that the stigma attached to mental illness was sometimes extended to professionals. A situation that was confirmed by family caregivers, and partly attributed to misconceptions about mental illness:

They discriminate against them [mentally ill people and family]. Especially, they are isolated when they have to be at a gathering. They do not listen to what patients have to say, it's like nothing good will come out of them. Relatives and patients themselves are restricted. For instance, people may not even buy food from them when they are selling because they have a myth that when you get close to people with mental illness you can also get the illness (Respondent 6, professional)

The truth is, society thinks you are destroyed when you get this condition so they don't value you any longer. Besides, the words from people sometimes stinks. For instance, I heard someone saying sometime back that even the professionals who take care of them sometimes behave like the patients (Respondent 20, family caregiver)

In whole, caregivers related society's attitude towards them to stigma and discrimination. Although largely experienced by family caregivers and their relatives with mental illness, professionals were sometimes stigmatised.

#### **4.2.2.10 Effect of Society's Attitude towards Caregivers of Persons with Mental Illness**

There was a noted effect of the negative attitude of society (stigma and discrimination) on caregivers. This effect was mostly noted to be affective in nature. Basically, the mood of the caregivers was disturbed to some extent. Generally, family caregivers (6) were more affected than professionals (5). Yet, some caregivers (4 professionals, and 3 family caregivers) were not disturbed by society's display of stigma: Examples of the affective symptoms elicited by society's attitude in caregivers included: sadness, regrets, worry, and embarrassment.

This makes me feel sad because most of the patients we talk to do not feel comfortable because of the stigma. So at times they do not want you to visit them for fear that people may suspect they have a problem. This does not help with their recovery as they think a lot... (Respondent 10, professional)

People say different things about her condition, some even say she is mad, and that worries me (Respondent 17, family caregiver)

In brief, family caregivers (6) were more affected by society's negative attitude (stigma and discrimination) than professionals (5). Nonetheless, there were few caregivers who were not affected. The effect was mood or affective oriented.

#### **4.2.2.11 Coping Strategies**

Eventually, caregivers employed certain strategies to cope with unfavourable circumstances that accompanied their role as caregivers of persons with mental illness. These

were perceived to reduce their burden. Accounts by caregivers were captured under five (5) domains, including: Rationalisation; tactical or planned ignoring; self-motivation; Acceptance; and use of religion.

***Rationalisation:*** Rationalisation was commonly used by 7 professionals and 1 family caregiver. In this instance, respondents provided an explanation and justification for the negative attitudes of others towards them. Caregivers cited lack of knowledge of mental illness as the main reason for people's negative attitudes and therefore recounted the need to educate people who stigmatised or mistreated caregivers or persons with mental illness on mental health and mental illness. Thus, people who stigmatised were perceived as targets for education:

I am able to cope well because I think they do not know much about the condition, and that is why they discriminate. I see it as ignorance, and education is the key (Respondent 1, professional)

I try to explain to even close relatives who get to know about her condition, that it was the result of a stressful experience she had from her relationship, and that helps me to cope (Respondent 17, family caregiver)

***Tactical or Planned Ignoring:*** Some caregivers gave account for the use of tactical or planned ignoring to deal with the negative attitudes from society. With this, undesirable statements or actions by society were considered irrelevant, hence, not given attention. This strategy appeared helpful, as caregivers described how disheartening attitudes were not entertained to affect their emotions and behaviour. This strategy was used by 2 professionals, and 1 family caregiver:

Sometimes you hear what people say and you just ignore. You don't really take it to heart so much because they may not know what they are saying or they may not have knowledge in mental health. Hence, you even take the opportunity to educate them to be well informed (Respondent 8, professional)

When I hear anybody talking about my relative's condition, I just ignore and move on in life because that is their opinion (Respondent 14, family caregiver)

***Self-Motivation:*** The use of self-motivation was only common among professionals (4) in the present study. As described, professionals could only afford being intrinsically motivated, considering the current state of CBMH in Ghana. Much of their inner drive was informed by their knowledge and achievements. Instances were given where professionals got motivated by their patients' recovery outcomes, or a sense of strength in their patients:

Well, the only strategy for coping is that, if at the end of the day I see that I'm successful with the case, I'm fine. It's like fulfilment and then job satisfaction (Respondent 6, professional)

I always take inspiration from the fact that patients themselves encourage you at times. Patients tell us that sometimes when society says things that can make uncomfortable, they just get into their rooms... I forget about everything when I close from work, and I also encourage people not to look only at the negatives, but also the positive side of the patients (Respondent 10, professional)

***Acceptance:*** Acceptance coping was used by 2 family caregivers, and 1 professional. The use of acceptance coping in a professional meant accepting the challenges that accompanied

mental health service delivery, whereas family caregivers used acceptance coping when they attributed their mentally ill relative's condition to a natural occurrence:

I have accepted it as normal and part of the work, so I take it like that (Respondent 5, professional)

I have accepted the fact that nobody wishes this condition on themselves, and it can happen to anybody. It is no respecter of persons. Both the rich and the poor can be affected. I see it as how a tragedy can kill someone who is not sick (Respondent 20, family caregiver)

***Use of Religion:*** Finally, religious coping was basically employed by family caregivers. Six (6) out of 10 family caregivers resorted to faith as a means of hope and comfort: Mostly, family caregivers got inspiration from the messages they read from the Bible. Also, their participation in church activities was perceived to relieve them of their worries, which emanated from their persistent thoughts about their relatives' mental health problems:

I cope with the word of God, there are passages that speak to your soul, to comfort you when you are down (Respondent 18, family caregiver)

... I read [my Bible] and also go to church, although on Sundays only for now, and also take part in certain activities in church to help me reduce my excessive thinking (Respondent 16, family caregiver)

In sum, there were five (5) strategies employed by caregivers of persons with mental illness to cope with the stress associated with caregiving. These were: rationalisation, tactical ignoring or planned ignoring, self-motivation, acceptance, and the use of religion. Ultimately, there was a difference between professionals and family caregivers in the types of coping

strategies used. Basically, more professionals (7) used rationalisation than family caregivers (1). Again, more professionals used tactical or planned ignoring than family caregivers. On the other hand, more family caregivers used acceptance than professionals. Nonetheless, whereas self-motivation was used only by professionals (4), religious coping was mainly employed by family caregivers (6). Moreover, not only did rationalisation emerge the most commonly used coping strategy among professionals, but was also the most frequently used coping strategy among the five (5) forms of coping identified in the qualitative aspect of the present study. Likewise, religious coping was the most rated coping strategy among family caregivers.

### **4.3 Quantitative Results**

This sub-section presents findings of the quantitative aspect of the present study. These findings are based on the study's formulated hypotheses on differences in stress, affiliate stigma, wellbeing and coping strategies among community and institutional family caregivers; the impact of caregiver stress and affiliate stigma on caregiver wellbeing; as well as the relationship between coping strategies and caregiver wellbeing, in line with the study's objectives. These hypotheses were tested with the aid of the IBM SPSS (Statistical Package for Social Science) version 23.0. A Multivariate Analysis of Covariance (MANCOVA) was used to assess differences between community and institutional family caregivers in stress, affiliate stigma, and wellbeing. Again, MANCOVA was used to investigate differences between community and institutional family caregivers in the types of coping strategies used. Nevertheless, Hierarchical Multiple Regression analysis was used to examine the impact of caregiver stress and affiliate stigma on wellbeing, and the relationship between coping strategies and caregiver wellbeing. Besides, supplementary findings, relevant to the study's discussion, although did not form part of the study's hypotheses were noted.

### 4.3.1 Preliminary Analysis

There was a 100 percent response rate as all individuals who were approached participated in the study. Also, initial data screening found no missing data as questionnaires were scrutinised for completeness before collection from respondents. The continuous variables were inspected for normality by assessing skewness, Kurtosis and outliers. The variables were well within acceptable ranges of -2 to +2 for skewness and -7 to + 7 for kurtosis (Byrne, 2016; Hair et al., 2010). The means, standard deviations and Cronbach' alphas for each of the scales and subscales of the Brief COPE used (see Table 2) had a Cronbach' alpha above .7 (Pallant, 2011).

**Table 1**

*Mean, Standard Deviation, Cronbach Alpha, Skewness and Kurtosis for the study variables (n = 280)*

Variable	<i>M</i>	<i>SD</i>	Cronbach' Alpha ( $\alpha$ )	Skewness	Kurtosis
Caregiver stress	23.16	9.26	.92	.44	-.52
Caregiver Wellbeing	52.36	9.19	.84	-.56	.77
Affiliate Stigma	44.03	10.92	.94	.36	1.21
Brief COPE Subscales					
Active Coping	6.85	1.68	.80	-1.29	.53
Acceptance	6.18	1.98	.82	-.74	-.66
Religion	7.13	1.58	.87	-1.74	2.16
Emotional support	5.11	1.95	.83	-.26	-1.01
Denial	3.57	2.03	.79	1.02	-.28
Self-Blame	2.91	1.62	.90	1.91	2.81
Substance Use	2.77	1.49	.97	1.98	3.17

### 4.3.2 Hypotheses Testing

An initial Pearson Product-Moment Correlation Coefficient analysis was conducted to examine existing relationships between the study's variables and demographic characteristics. This correlation analysis revealed that age, sex, number of years as a carer, relationship with patient, highest level of education, marital status, and income status significantly correlated with some of the study's dependent variables (see Table 3). Hence, age, sex, number of years as a carer, relationship with patient, highest level of education, marital status and income status were treated as control variables in the subsequent statistical tests used.

Hypothesis one assessed the difference between community and institutional family caregivers in stress, affiliate stigma and wellbeing, while controlling for age, number of years as a carer, relationship with patient, highest level of education, and income status (see Table 4). MANCOVA was used to test hypothesis one (1) because the dependent variables were found to be moderately related (Cohen, 1988) as presented (see Table 3). Similarly, MANCOVA was used to test hypothesis two (2) which assessed the difference between the two groups of family caregivers in the types of coping strategies used, controlling for age, sex, number of years as a carer, relationship with patient, and marital status (see Table 5). Hypothesis three (3) which examined the impact of caregiver stress and affiliate stigma on caregiver wellbeing controlling for potential covariates, and Hypothesis four (4) which assessed the relationship between coping strategies and caregiver wellbeing controlling for identified covariates were each tested with Hierarchical Multiple Regression analysis (see Table 6 and Table 7).

**Table 2**

*Pearson Product-Moment Correlation Coefficient between Study Variables and Demographic Characteristics*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1.CS	-																	
2.AS	.56***	-																
3.CW	-.39**	-.29***	-															
4.AC	.03*	.05	.09	-														
5.Accept	.10	.10	.09	.49**	-													
6.RL	.01	-.01	.05	.51***	.33***	-												
7.ES	.01	-.01	.05	.35***	.18**	.32**	-											
8.Denial	.17**	.23**	-.23***	-.06	-.26***	.13*	.14*	-										
9.SB	.21***	.27**	-.28***	-.09	-.07	-.01	.06	.45***	-									
10.SU	.19**	.22**	-.20**	-.12**	-.06	-.01	-.01	.23**	.18**	-								
11.Sex	.04	.05	-.04	.06	-.03	.20**	.10	-.03	.02	.01	-							
12.Age	-.01	.01	.17**	-.02	.05	.03	-.05	-.22***	-.13*	-.05	.10	-						
13.NC	.03	-.02	.15**	-.14**	-.02	-.06	-.01	-.09	-.08	-.03	.09	.37**	-					
14.RP	.14*	.04	-.10	-.01	.01	.05	.15**	.10	.06	.07	.03	-.04	-.02	-				
15.HE	-.13*	-.15**	.15*	.02	.08	-.06	.08	-.09	-.05	-.10	-.13*	-.11	.03	-.02	-			
16.RA	.05	.05	-.03	-.05	-.07	-.03	.03	.04	.03	.06	-.04	-.02	-.06	.09	.12	-		
17.MS	.10	.07	-.01	-.01	.08	-.04	.02	-.14*	.05	-.04	.21***	.39**	.05	.06	-.17**	-.05	-	
18.IS	-.17***	-.13*	.09	.06	-.11	-.09	.08	.06	.05	-.05	-.17**	-.10	-.08	-.03	.48**	.12*	-.15**	-

Note: \*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$ . CS = Caregiver Stress, AS = Affiliate Stigma, CW = Caregiver wellbeing, AC = Active Coping, Accept = Acceptance Coping, RL = Religion, ES = Emotional Support, Denial, SB = Self-Blame, SU = Substance Use, Sex, NC = Number of years as a Career, RP = Relationship with Patient, HE = Highest Level of Education, RA = Religious Affiliation, MS= Marital Status and IS = Income Status

#### 4 3.3.1 Hypothesis One

This hypothesis stated that perceived stress, affiliate stigma and wellbeing will significantly differ between community and institutional family caregivers, after controlling for potential covariates.

H1 a. Perceived stress will be significantly higher among community family caregivers than it will be among institutional family caregivers.

H1 b. Affiliate stigma among community family caregivers will be significantly higher than it will be among institutional family caregivers.

H1 c. Community family caregivers will report significantly lower wellbeing than institutional family caregivers.

Results from MANCOVA (see Table 4), controlling for age, number of years as a carer, relationship with patients, highest level of education and income status indicated a statistically significant difference between community and institutional family caregivers in the combined dependent variables (caregiver stress, affiliate stigma, and caregiver wellbeing), Wilks' Lambda = .95,  $F_{(3, 271)} = 4.89$ ,  $p < .05$ ; partial eta squared = .05. Hence, the main hypothesis that perceived stress, affiliate stigma and wellbeing will significantly differ among community and institutional family caregivers was supported by the data. However, the univariate results revealed no statistical significant differences between community and institutional family caregivers in stress, ( $F_{(1, 273)} = 2.51$ ,  $p > .05$ ) and affiliate stigma, ( $F_{(1, 273)} = .44$ ,  $p > .05$ ). Yet, there was a statistical significant difference in the mean scores of community ( $M = 53.91$ ,  $SD = 9.30$ ) and institutional family caregivers ( $M = 50.81$ ,  $SD = 8.83$ ) in wellbeing,  $F_{(1, 273)} = 4.80$ ,  $p < .05$ , partial eta squared = .02 (see Table 4). That is, community family caregivers had a higher score on wellbeing, which was not in the researcher's predicted direction. The specific

assumptions under hypothesis one (H1a, H1b and H1c), informed by Perneger's (1998) argument against the use of Bonferroni adjustments were rejected.

**Table 3**

*Results of MANCOVA on Caregiver Stress, Affiliate Stigma and Caregiver Wellbeing of Community and Institutional Family Caregivers*

Dependent Variable	Community Family Caregivers		Institutional Family Caregivers		<i>F</i>	<i>P</i>	$\eta^2$
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Caregiver Stress	23.83	9.49	22.50	9.01	2.51	.12	.01
Affiliate Stigma	43.41	11.08	44.65	10.77	.44	.51	.00
Caregiver Wellbeing	53.91	9.30	50.81	8.83	4.80	.03	.02

#### 4.3.3.2 Hypothesis Two

This hypothesis stated that, there will be a significant difference between community and institutional family caregivers in the types of coping strategies used to manage stress after controlling for potential covariates. The results of the initial Pearson Product-Moment Correlation Coefficient analysis showed existing relationships between the coping strategies and age, sex, number of years as a carer, relationship with patient and marital status. (See Table 3). However, results from MANCOVA (see Table 5) indicated no statistically significant difference between community and institutional family caregivers in the types of coping strategies used (i.e. Active Coping, Acceptance, Religion, Emotional Support, Denial, Substance Use, and Self Blame), Wilks' Lambda = .95,  $F(7, 267) = 1.86$ ,  $p > .05$ ; partial eta squared = .05. Hence, the hypothesis that there will be a significant difference between community and institutional family caregivers in the types of coping strategies used to manage stress was not supported by data.

**Table 4**

**Results of MANCOVA on Coping Strategies of Community and Institutional Family Caregivers**

Dependent Variable	Community Family Caregivers		Institutional Family Caregivers		<i>F</i>	<i>P</i>	$\eta^2$
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Active Coping	6.76	1.75	6.94	1.60	.39	.53	.00
Acceptance Coping	5.96	1.87	6.40	2.06	3.24	.73	.01
Religion	7.17	1.55	7.09	1.61	.29	.59	.00
Emotional Support	5.07	2.16	5.14	1.72	.01	.93	.00
Denial	3.56	1.87	3.57	2.19	.12	.73	.00
Self-Blame	2.64	1.40	3.18	1.78	6.16	.01	.02
Substance Use	2.71	1.48	2.83	1.50	.28	.60	.00

#### 4.3.3.3 Hypothesis Three

This hypothesis stated that, caregiver stress and affiliate stigma will negatively predict caregiver wellbeing controlling for potential covariates. In Table 6 below, the second Step ( $F_{(7, 272)} = 10.47, p = .000, R^2 = .21$ ) which is the summary of overall contributions of the variables was significant. This indicates that all the study variables together accounted for a 21% variance in caregiver wellbeing. In Step 1 where age, number of years as a carer, relationship with patient, formal education, and income status were entered as control variables, the model ( $F_{(5, 274)} = 4.14, p = .001, R^2 = .07$ ) was significant. This indicates that age, number of years as a carer, relationship with patient, formal education, and income status accounted for a 7% variance in caregiver wellbeing. The second Step, ( $F_{(7, 272)} = 10.47, p = .001, \Delta R^2 = .142$ ) was also significant. Thus, both caregiver stress and affiliate stigma accounted for a 14.2% variance in caregiver wellbeing. It was further realized that caregiver stress significantly predicted caregiver

wellbeing ( $\beta = -.329, p < .001$ ) whereas affiliate stigma did not significantly predict caregiver wellbeing ( $\beta = -.089, p > .05$ ). In summary, the hypothesis that “caregiver stress and affiliate stigma will negatively predict caregiver wellbeing controlling for potential covariates” was partially supported.

**Table 5**

***Hierarchical Multiple Regression for the Impact of Caregiver Stress and Affiliate Stigma on Caregiver Wellbeing***

	B	SE	$\beta$	t	p
Step 1. Age	.097	.040	.155	2.435	.016
Number of years as a carer	.105	.066	.100	1.597	.112
Relationship with client	-.547	.349	-.091	-1.568	.118
Formal Education	2.939	1.504	.119	1.955	.052
Income status per month	.550	.428	.078	1.283	.201
Step 2. Age	.091	.037	.145	2.470	.014
Number of years as a carer	.112	.061	.108	1.850	.065
Relationship with client	-.253	.326	-.042	-.778	.437
Formal Education	2.560	1.390	.103	1.841	.067
Income status per month	.113	.401	.016	.282	.778
Caregiver Stress	-.327	.066	-.329	-4.984	.000
Affiliate Stigma	-.075	.055	-.089	-1.373	.171

*Note: Step 1,  $R^2 = .07, F = 4.14$ ; Step 2,  $R^2 = .21, \Delta R^2 = .142, F = 10.47$*

#### **4.3.3.4 Hypothesis Four**

The variables altogether were significant in predicting caregiver wellbeing as evident in the second model. The total variance explained by the predictor variables was 16% ( $F_{(12, 267)} = 4.247, p < .05, R^2 = .16$ ). The first step (see Table 7) where sex, age, number of years as a carer, relationship with patient and marital status were controlled, the model ( $F_{(5, 274)} = 4.142, p < .05, R^2 = .07$ ) was significant. This indicates that sex, age, number of years as a carer, relationship

with patient and marital status accounted for a 7% variance in caregiver wellbeing. In step 2, coping strategies accounted for a 9% variance in caregiver well-being ( $F_{(12, 267)} = 4.247, p < .05, R^2 = .160, \Delta R^2 = .09$ ) when entered. However, even though the model was significant, only self-blame ( $\beta = -.193$ ) and substance use ( $\beta = -.124$ ) significantly predicted caregiver wellbeing. Thus, the hypothesis that coping strategies will have a significant relationship with caregiver wellbeing controlling for potential covariates was partially supported by data.

**Table 6**

***Hierarchical Multiple Regression for Relationship between Coping Strategies and Caregiver Wellbeing***

	B	SE	$\beta$	<i>F</i>	<i>P</i>
Step 1. Age	.10	.04	.16	4.14	.02
Number of years as a carer	.11	.07	.10		.11
Relationship with patient	-.55	.35	-.09		.12
Formal Education	2.94	1.50	.12		.05
Income status per month	.55	.43	.08		.20
Step 2. Age	.07	.04	.11	4.25	.09
Number of years as a carer	.10	.06	.10		.12
Relationship with patient	-.45	.34	-.08		.19
Formal Education	2.08	1.47	.08		.16
Income status per month	.62	.42	.09		.14
Active coping	.07	.41	.01		.87
Acceptance	.11	.32	.02		.72
Religion	.22	.40	.04		.59
Emotional support	.25	.30	.05		.40
Denial	-.35	.32	-.08		.27
Self-Blame	-1.10	.36	-.19		.00
Substance Use	-.77	.36	-.12		.03

Note: For Step 1,  $F = 4.142, R^2 = .070$ ; Step 2,  $F = 4.247, \Delta F 4.089, \Delta R^2 = .090$

#### 4.4 Additional Findings

1. The use of self-blame as a coping strategy was higher among institutional family caregivers ( $M = 3.18$ ,  $SD = 1.78$ ) than it was among community family caregivers [ $(M = 2.64$ ,  $SD = 1.39$ ; see Table 5)].
2. Substance use was higher among institutional family caregivers ( $M = 2.83$ ,  $SD = 1.50$ ) than it was among community family caregivers [ $(M = 2.71$ ,  $SD = 1.48$ ; see Table 5)].

#### 4.5 Summary of Findings of the Study

This sub-section of the results chapter presents a summary of findings from the analysis of the qualitative and quantitative data that was obtained. The qualitative findings precede the quantitative findings as presented:

##### 4.5.1 Summary of Qualitative Findings

A qualitative exploration of caregiver experiences in community-based mental health care revealed much about mental health professionals and family caregivers. To a largely extent, professionals and family caregivers agreed on the perceived benefits of CBMH. The model was found to provide an avenue for the expression of challenges by patients; build trust from one-on-one contact with patients; facilitate integration and reduce stigma; provide avenue for education, which reduces stigma and discrimination; enhance patients' activity level; build confidence in patients through acceptance and sense of belonging; and reduce patients' length of stay in hospital. The model was also appreciated for its convenience of care delivery, and cost effectiveness although there were challenges.

The risk associated with mental health service delivery, as well as structural and resource challenges which comprises of lack of logistics, human resource, and support for mental health services; inadequate funding; difficulty locating patients' homes during home visits; and unsafe

patient's home environment, affected professionals than family caregivers. On the other hand, family caregivers were much affected by noncompliance; inappropriate behaviour; prolonged contact with an indifferent relative; time constraints and inability to work in CBMH. Family caregivers were noted to have inadequate skills in managing relatives with mental illness. Generally, professionals were much affected by these challenges than family caregivers. Moreover, there were challenges with INST which affected both professionals and family caregivers. Confinement; aggression; abandonment by family; and accumulation of deficit symptoms were of much concern to caregivers in general. Again resource and infrastructural challenges in INST affected professionals than family caregivers. Nonetheless, family caregivers found the high cost of INST very challenging.

In addition, the stigma attached to mental illness, although directed at sufferers was extended to family caregivers and sometimes professionals. In whole, caregivers perceived society's attitude towards them as one of stigma and discrimination, the effect of which was more of mood or affective oriented. Yet, some caregivers (4 professionals, and 3 family caregivers) were not affected. All these challenges were observed to have amounted to caregiver stress and affiliate stigma. This situation was perceived to affect caregiver wellbeing.

There were differences between professionals and family caregivers on the effect of CBMH on finances, career, activities of daily living, and wellbeing. The present study found a more negative effect of CBMH on the finances of professionals (7) than family caregivers (3). Thus, the cost effectiveness of CBMH, was only in favour of family caregivers (5). Yet, whereas CBMH negatively affected the career of 7 family caregivers, 7 professionals perceived a positive impact of CBMH on their career. Moreover, the daily activities of family caregivers (6) in CBMH were more affected than that of professionals (5). Eventually, family caregivers (10) were more affected on wellbeing than professionals (7). However, whereas family caregivers had

an equal effect of CBMH on their physical and psychological wellbeing, professionals (6) were more affected on their physical wellbeing than psychological wellbeing (1). Generally, professionals (7) found CBMH more stressful than family caregivers (5).

Even so, CBMH was the preferred model for mental health care to caregivers (10 professionals and 5 family caregivers) although the model was noted not to be fully functioning. Ultimately, caregivers (8 professionals, and 7 family caregivers) supported the shift from INST to CBMH despite existing challenges. In keeping with this support were various strategies employed by caregivers to cope.

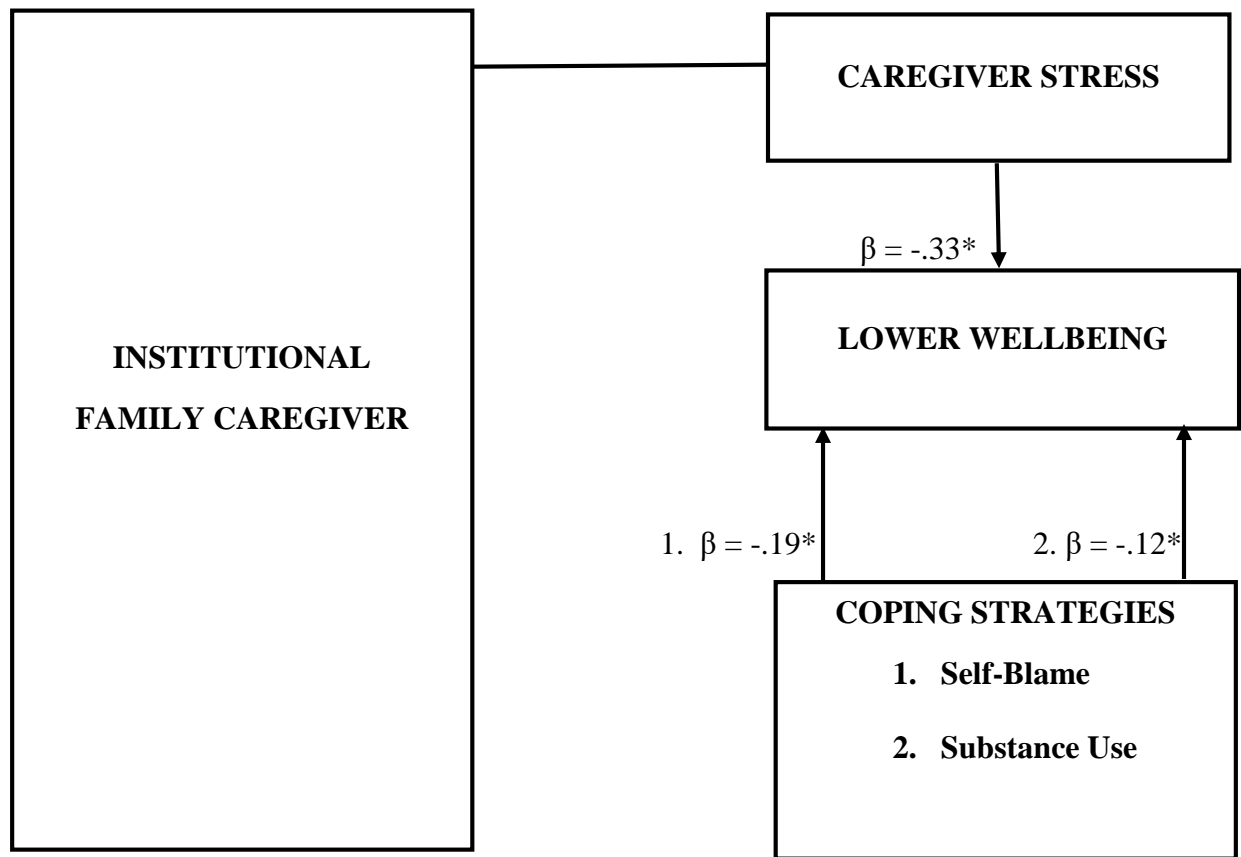
Essentially, there were five (5) coping strategies employed by caregivers. These included rationalisation, tactical ignoring or planned ignoring, self-motivation, acceptance, and religious coping. However, there was a difference between professionals and family caregivers with these coping strategies. Basically, more professionals (7) used rationalisation than family caregivers (1). Again, more professionals (2) used tactical or planned ignoring than family caregivers (1). On the other hand, more family caregivers (2) used acceptance coping than professionals (1). Nonetheless, whereas self-motivation was used only by professionals (4), religious coping was mainly employed by family caregivers (6). Yet, whereas rationalisation emerged the most commonly used coping strategy among mental health professionals, and the most rated coping strategy among the five (5) strategies for coping identified by the qualitative aspect of the present study, religious coping was the most rated strategy among family caregivers.

Correspondingly, caregivers shared their thoughts for improving CBMH. These were targeted at reverting the existing challenges with CBMH. Both professionals and family caregivers agreed on the need for provision of essential resources; stakeholder engagement for assistance; capacity building and professional assistance for family caregivers; reduction in stigma and discrimination; caregiver welfare; and Support from government.

#### 4.5.2 Summary of Quantitative Findings

There was a statistically significant difference between community and institutional family caregivers in the combined experience of caregiver stress, affiliate stigma and caregiver wellbeing. This was identified after controlling for age, number of years as a carer, relationship with patient, highest level of education, and income status. However, the stress and affiliate stigma experienced by the two groups of family caregivers did not differ, although there was a difference in their wellbeing. Both caregiver stress and affiliate stigma had impact on caregiver wellbeing controlling for potential covariates.

The observed model (Figure 4) offers a description of the experiences of community and institutional family caregivers. The scores from the analysis of the quantitative data obtained revealed that institutional family caregivers had a lower wellbeing than community family caregivers. Also, only caregiver stress significantly predicted caregiver wellbeing. Although the stress and affiliate stigma experienced by the two groups did not significantly differ, the lower wellbeing of institutional family caregivers could be linked to the nature of stress experienced. Again, even though a relationship between coping strategies and caregiver wellbeing was established, only self-blame and substance use significantly predicted caregiver wellbeing, which were all in the negative direction. Further analysis showed that these two maladaptive coping strategies were higher among institutional family caregivers than they were among community family caregivers, which also explains the lower wellbeing of institutional family caregivers. It is however worth noting that, the observed model concentrated on findings that were statistically significant. Moreover, the quantitative aspect of the study focused only on family caregivers.



*Figure 4: Summary of the Observed Relationship between the Study Variables*

## CHAPTER FIVE

### DISCUSSION

#### 5.1 Introduction

This chapter contains the discussion of findings, implications, limitations, recommendations, and conclusions from the present study. The main aim of the study was to explore the experiences of caregivers (professionals and family caregivers) in community-based mental health care, which is a recommended model for mental health care by WHO (Alem et al., 2008). This exploration was guided by the Social Model of Health, and supported by the social determinants of health theory often used by WHO to explain population health, including mental health (Dean et al., 2013). The study was conducted using mixed methods approach, the timing of which was concurrent. The qualitative aspect explored the experiences professionals and family caregivers in general, whereas the quantitative aspect concentrated on two (2) groups of family caregivers (i.e. Community and institutional). Both aspects (qualitative and quantitative) of the study focused on caregiver experiences in community-based mental health care. To help understand these experiences, caregiver stress, affiliate stigma, caregiver wellbeing, and coping strategies used were investigated.

Findings from the qualitative aspect of the study indicated differences in the experiences of professionals and family caregivers, even though the two groups acknowledged the model's effectiveness. Also, the quantitative aspect of the study found a difference between community and institutional family caregivers in the combined experience of stress, affiliate stigma and wellbeing, even though the stress and affiliate stigma experienced by these two groups of family caregivers did not differ. Besides, caregiver stress and affiliate stigma had an impact on caregiver wellbeing, with caregiver stress significantly predicting wellbeing negatively. Nonetheless, though the qualitative findings showed differences in the types of coping strategies used by

professionals and family caregivers, the findings of the quantitative aspect of the study demonstrated no difference in the types of coping strategies used among community and institutional family caregivers. Yet, there was a relationship between coping strategies and caregiver wellbeing.

As complements, the study's qualitative findings deepen the understanding of its objective outcomes by providing details of experiences, and vice versa (Creswell, 2013; Johnson & Onwuegbuzie, 2004). The intersection of the qualitative and quantitative aspects of the present study is presented in the discussion of the findings, which is shaped along the study's objectives to provide a universal understanding of caregiver experience in community-based mental health care in Ghana.

## **5.2 Discussion of Caregiver Experience in Community-Based Mental Health Care**

### ***Benefits of Community-Based Mental Health Care***

The main aim of the study was to explore the experiences of professionals and family caregivers in community-based mental health care. First, the findings revealed acknowledgement of the model's effectiveness for the care of persons with mental illness. This was because CBMH was perceived to afford social support from family; offer avenue for the expression of challenges; was convenient for care delivery; build trust from one-on-one contact with patients; provide avenue for education which reduces stigma and discrimination; facilitate integration; enhance patients' activity level; build confidence in patients through acceptance and sense of belonging; reduce the length of patients' stay in hospital; and cost effective. These findings coincide with the benefits of CBMH reported by a previous study (Kumar, 2011).

From these findings, it was observed that the home environment was perceived as an ideal context for the care of persons with mental illness. This was because patients were surrounded by familiar people and environment (Deb, McGirr, Bhattacharya, & Sun, 2015). For

instance the family has been recognised as a support system that plays a protective role against psychological distress (Berkman, 2014), for which their exclusion from patients' care was deemed to attract negative consequences (Leggatt, 2002). Also, Smith, Saunders, Stuckhardt, McGinnis, and Editors (2012) confirm that an avenue is offered by the community setting for the expression of challenges which can be linked to the one-on-one contact with patients while ensuring privacy and confidentiality. The importance of maintaining privacy and confidentiality to enhance effective communication was confirmed by Medsker, Forno, Simhan, Juan, and Sciences (2016). Again, the convenience of service delivery, which improves access to care, thereby averting relapse and facilitating effective integration of patient into the community is consistent with findings of Tlhowe, du Plessis, and Koen (2017).

Moreover, the opportunity provided for education to reduce stigma is in line with findings of previous studies (Collins, Wong, Cerully, Schultz, & Eberhart, 2013; Leff, 2002) that found education key towards the reduction of stigma attached to mental illness. Also, findings on the increase in patients' activity level in CBMH necessary to deter feelings of restriction or imprisoned in patients, as is the case with institutional care is similar to the findings of previous researchers (Thornicroft & Tansella, 2003). According to Jacob (2015), there is enough proof to substantiate the claim that involvement in social, occupational, volunteering and instructional prospects can facilitate recovery. CBMH therefore helps to reduce the length of patients' stay in hospital, which is peculiar with existing literature (Killaspy, 2006). Thus, there is a corresponding reduction in cost, which affirms the cost effectiveness of CBMH (Wiley-Exley, 2007). Eventually, the community setting has been noted essential to guarantee the effectiveness of CBMH and the satisfaction of patients and their families (Henderson, Phelan, Loftus, Dall'Agnola, & Ruggeri, 1999). Notwithstanding, caregiver experience in CBMH was not limited to its associated benefits.

### ***Challenges of Community-Based Mental Health Care***

There were challenges with CBMH, which emanates from resources and vital structure constraint; risk associated with caregiving; burden or stress associated with caregiving; stigma and discrimination. These are consistent with findings of previous studies (Doku et al., 2012; Marais & Petersen, 2015; Walker, 2015) and presented with the need to be concerned as per existing evidence (Wild et al., 2012) on the negative effect of resource deficit on levels of performance. The risk associated with mental health service delivery is consistent with the findings of a previous study (Crowe & Carlyle, 2003). Basically, the present study found professionals to be more affected. In CBMH, the patient's home environment was perceived unsafe during home visits due to instances of dog bites and sexual harassment by some patients.

Moreover, a report on the burden or stress associated with CBMH by professionals and family caregivers is consistent with findings of previous studies (Fothergill et al., 2004; WHO, 2003). In CBMH, professionals were found to be more affected on finances, which was basically due to the cost of transport, communication, and assistance given to patients who could not afford treatment. Clearly, there was inadequate funding for mental health service delivery to have averted such instances, which is consistent with existing literature (Hanlon et al., 2010). Again, professionals described difficulties involved in locating patients' homes during visits, owing to poor roads and landmark system, as well as poor weather conditions.

On the other hand, treatment noncompliance, time constraints, inappropriate behaviour, prolonged contact with an indifferent relative, and inability to work, were particularly stressful for family caregivers. Treatment noncompliance identified in the present study is consistent with an existing evidence that confirmed that it is more common for persons with mental illness not to stick to medication regimen, although the phenomenon exists in all fields of medicine (Kane, Kishimoto, & Correll, 2013). Correspondingly, Rana and Ayub (2002) presented evidence of

noncompliance with medication in psychiatric patients and noted how compliance is meticulously handled in institutions, but almost left to patients while at home.

Major reasons reported for noncompliance included: families not supporting patients, as well as adverse effects of medications such as sleepiness, weakness, powerlessness and loss of energy. Besides, Rana and Ayub (2002) indicated possible reasons for noncompliance to include the lack of insight into patients' condition; instability and homelessness; and the knowledge of possible addiction to medication. Consequently, Kane et al. (2013) discussed the possibility of relapse when medications are discontinued.

The resultant change in patient's behaviour following noncompliance was identified to burden family caregivers. The present study noted instances where inappropriate behaviour led to patient abandonment, even by loved ones. Respondents drew attention to instances where they felt embarrassed and uncomfortable with patients' behaviour, especially when they had visitors, prolonged contact with indifferent mentally ill relatives who refused or could not respond or interact with people at home, yet were able to communicate effectively with others when they went out. It was in no doubt to family caregivers that the lack of respect for persons with mental illness was due to behaviours considered inappropriate. However, a most disturbing experience in CBMH to family caregivers was the negative impact of CBMH on their time.

Eventually, there were family caregivers who could not perform as expected in their jobs, and others who could not engage in economic activities at all due to time used for caring for mentally ill relatives. Time constraints in family caregivers of persons with mental illness are consistent with evidence from an existing study (Vermeulen et al., 2015). The challenge with time for family caregivers in CBMH was however not the case in INST, although INST also presented some challenges to both professionals and family caregivers.

Challenges noted in INST by the present study were: Confinement; aggression; abandonment by families; infrastructural and resource deficits; accumulation of deficit symptoms; and high cost. These findings are similar to that of previous researchers (Kofie & Montana, 2017; McDaid & Thornicroft, 2005; Thornicroft & Tansella, 2003), some of which resulted in a disregard for patients' rights, not to mention INST aiding with patients' recovery (McDaid & Thornicroft, 2005). Essentially, confinement was perceived to result in boredom, especially when activities in INST were routine (Antonysamy, 2013). The enclosed nature of institutional settings clearly deprived patients of their freedom of movement as well as the opportunity to better themselves with various vocational and lucrative activities afforded by CBMH. As noted by the present study, feelings of imprisonment were inevitable in patients who identified nurses in uniforms with an invisible power in hospital settings. An observation that is consistent with existing literature (Cutcliffe & Happell, 2009).

Still among the challenges with INST is aggression, often considered an everyday happening with psychiatric care (Crowe & Carlyle, 2003). Aggression was however found to particularly expose professionals and other patients to risk by the present study, and is consistent with the findings of a previous study (Antonysamy, 2013). Antonysamy (2013) provided much insight into how aggression results. Basically, accrued anger and frustration in persons with mental illness was a possible trigger of aggression. Furthermore, Antonysamy discouraged the use of methods such as restrain and sedation as means of managing aggression and rather promoted patients' involvement in therapeutic activities. However, the present study established the need for vigilance as a measure for safety in institutional settings, a view that is also supported by an existing research (Slemon, Jenkins, & Bungay, 2017) which argued for the importance of seclusion in addition to observations, defensive nursing practice, and door locking, although acknowledged the growing evidence that discredited their effectiveness.

Furthermore, abandonment of patients was identified with INST. This is when families begin to shove the burden or stress associated with caregiving to professionals. Although Iseselo et al. (2016) provided a contrasting finding, the act of family caregivers deserting their mentally ill relatives in institutions is acknowledged by other studies (Lund et al., 2011; da Silva & Monteiro, 2011). Yet, there are infrastructural and resource deficits in INST.

According to McDaid and Thornicroft (2005), until the last thirty (30) years when advocacy for community-based mental health care was intensified, the care of persons with mental illness was relegated to institutions (psychiatric hospitals) or the more historic asylums. Nonetheless, the present study identified problems with limited space, fewer admission beds, inadequate or unavailability of needed psychotropic medications, low staff strength, absence of seclusion rooms, and other tools needed to assist with the management of patients and aggression. These were indicated by professionals to be worrying, especially when patients whose condition required observation and care in institutional settings were unable to access the type of care they needed. A situation that contributes to the mental health treatment gap in Ghana (Akapule, 2015). Moreover, the limited space did not present patients with the option of being nursed according to their conditions or managed in smaller groups. Consequently, the adoption of negative behaviour from others was inevitable and consistent with a previous study (Thornicroft & Tansella, 2003). The challenges identified with INST by the present study are similar to those of existing studies (Kofie & Montana, 2017; McDaid & Thornicroft, 2005; Thornicroft & Tansella, 2003), some of which resulted in a disregard for patients' rights, not to mention the models' ability to aid with patients' recovery (McDaid & Thornicroft, 2005). Yet, there is a contrasting finding of the present study on the cost of INST and CBMB.

According to family caregivers, admission charges, cost of transport for frequent visits to institutions when relatives with mental illness are admitted, and medications were expensive, a

conclusion that is in line with the literature (McDaid & Thornicroft, 2005). As a result, patients whose families could not afford treatment were likely to end up on the street as noted by the Chief Executive (CE) of the Mental Health Authority of Ghana, Dr. Akwasi Osei (Awaf, 2010). Meanwhile, professionals found CBMH a drain on their personal finances. Nevertheless, the issue of stigma and discrimination attached to mental illness was a common constraint in CBMH for both professionals and family caregivers.

According to respondents, although the stigma attached to mental illness pointed at sufferers, families and sometimes professionals were affected. This means that caregivers were likely to be exposed to similar experiences of persons with mental illness by virtue of association. This coincides with the findings of previous researches (Kapungwe et al., 2010; Lund et al., 2011; Thornicroft & Tansella, 2003). Various reasons were given on how stigma was perceived to be generated and maintained.

Notably, professionals attributed stigma to inadequate knowledge on mental health, enclosed settings in INST, and the wearing of uniform by mental health professionals in INST. Basically, the negative attitude of society perceived as stigma and discrimination was attributed to the lack of knowledge in mental health. As observed, there were instances where society related positively towards professionals, but stigmatised and discriminated against family caregivers and persons with mental illness. Likewise, this attitude was sometimes extended to mental health professionals, which is consistent with the literature (Kalra, 2012).

Also, mental health professionals assigned to INST duties were perceived to be more stigmatised than their colleagues who worked in CBMH. The basis for such conclusion was that, INST nurses were confined per their setting and wore uniforms whereas their colleagues in CBMH conducted their activities in usual clothing other than a uniform, in a least restrictive environment. To them, the uniform was likely to make nurses in INST look “in charge” (a sign

of authority, or control) to their patients, which strengthened an invisible power as confirmed by an existing research (Cutcliffe & Happell, 2009), necessary to disrupt therapeutic relationships. However, findings from the literature (Albert, Wocial, Meyer, Na, & Trochelman, 2008; Lehna et al., 1999) confirm that although uniforms communicated professionalism and or knowledge and skills of the nursing profession, as well as helping to create an identity (Timmons & East, 2011), Bright (2014) cautioned about the different messages uniforms could convey to an observer.

Thus, an individual's perceptual abilities was implicated as one of the factors necessary to derive meanings from uniforms. Again, depending on what uniforms meant for patients, the trust necessary for effective communication could be interrupted. On the other hand, family caregivers associated stigma and discrimination attached to mental illness to misconceptions that were usually powered by community gossips. Fundamentally, the challenges identified with CBMH by the present study present a negative experience, and account for caregiver stress and affiliate stigma.

### **5.3 Discussion of Caregiver Stress and Affiliate Stigma**

In line with the researcher's hypothesis, the combined experience of stress, affiliate stigma and wellbeing differed between community and institutional family caregivers. However, their perceived stress and affiliate stigma remained same, which contradicted the researcher's initial assumptions. This implies that, regardless of the setting (community or institution), family caregivers go through similar experiences of stress and affiliate stigma. This evidence is consistent with a previous study that found psychiatry to be stressful (Fothergill et al., 2004), and another that confirmed affiliate stigma among caregivers of persons with mental illness (Yin et al., 2014).

In line with stigma and discrimination, Kyei-Mensah (2016) noted some of the consequences of stigma attached to mental illness to include: sufferers' exclusion of communities, deprivation of basic human rights, such as the rights to health, social and economic wellbeing. Ultimately, the findings of a previous study confirm the retarding nature of stigma on recovery (Link et al., 2001). By virtue of association, the stigma and discrimination directed towards persons with mental illness transcends to caregivers (Yin et al., 2014). Following these thoughts, Mak and Cheung (2008) defined affiliate stigma as the degree of self-stigmatisation among relations of an affected interest group while developing a scale to assess same.

Nevertheless, Werner, Mittelman, Goldstein, and Heinik (2012) observed that, caregivers' view on stigma was linked with an added burden in existing related studies. Eventually, Iseselo et al. (2016) confirmed stigma as one of the factors that influence caregiver psychosocial wellbeing. Evidently, a previous study conducted by Liu (2011) which examined the connection between perceived stigma and depressive symptoms found that, perceived stigma among caregivers correlated with the experience of depressive symptoms, a situation that was intensified with a heightened perception of stigma..

Evidence of caregiver stress was validated by González -Salvador, Arango, Lyketsos, and Barba (1999) who found higher stress among caregivers of Alzheimer's patients, compared to a control group. Better still, Son, Shea, Femia, Zarit, and Parris Stephens (2007) further studied the objective and subjective forms of caregiver stress and noted care receivers' stressors to include inconveniences associated with the care receiver's conduct, and the caregiver's subjective feelings of burden as the two forms of caregiving stress. Clearly, inappropriate behaviours and indifferent attitude of persons with mental illness communicated by family caregivers by the present study, and the feelings of sadness, worry, embarrassment, and regrets revealed by caregivers are consistent with care receivers' stressors and caregivers' subjective feelings as

explained by Son et al., (2007). Eventually, both objective and subjective stressors have an impact on caregivers' wellbeing. In sum, caregiver stress and affiliate stigma have an impact on caregiver wellbeing. This was partially confirmed by the present study, although only caregiver stress significantly predicted caregiver wellbeing, which was in the negative direction.

#### **5.4 Discussion of Caregiver Wellbeing**

Specifically, the present study found community family caregivers to have a higher level of wellbeing than institutional family caregivers, in contrast to the researcher's hypothesis. Yet, there is no popular empirical support for such finding. However, a possible reason identified by the present study is the fact that the challenges associated with CBMH mostly affected professionals, whereas that of INST mostly affected family caregivers. It is therefore in the right direction to relate the negative effects of INST with the lower wellbeing of institutional family caregivers.

In any case, the findings of the present study showed that both professionals and family caregivers experienced an impact of caregiving on their physical and psychological wellbeing, which is consistent with the findings of previous studies (Pinquart & Sörensen, 2003; Son et al., 2007). In general, the present study found that family caregivers (10) were more affected on wellbeing than professionals (7). Furthermore, although family caregivers had an equal impact of caregiving in CBMH on their physical (5) and psychological (5) wellbeing, professionals had more physical (6) than psychological (1) effects of CBMH on their wellbeing. These findings, however, contradict with evidence of existing studies that found the psychological wellbeing of caregivers to be more affected (González-Salvador et al., 1999; Pinquart & Sörensen, 2003; Talley & Crews, 2007).

Yet, there are positive aspects of caregiving. For instance, a report on the positive effect of CBMH on professionals was given by the qualitative aspect of the present study to include

respect and feelings of importance which resulted from confidence gained through assisting persons with mental illness in the community. The positive aspects of caregiving, identified by the present study are consistent with the findings of a previous that found that caregivers had more resilience and understanding (Vermeulen et al., 2015). Even so, some caregivers (4 professionals and 3 family caregivers) reported no negative effect from their caregiving roles due to their coping strategies. Clearly, there is a link between caregiver wellbeing and coping (Kim et al., 2003).

### **5.5 Discussion of Coping Strategies**

The findings of the present study did not confirm the researcher's initial hypothesis that, there will be difference between community and institutional family caregivers on the types of coping strategies used to manage stress. Instead, the use of active coping, acceptance, religion, emotional support, denial, substance use, and self-blame were notable in both community and institutional family caregivers. This result is however not consistent with the findings of a previous study that found a partial difference between orphaned children and non-orphans in the types of coping strategies used to manage stress (Salifu Yendork & Somhlaba, 2014). Thus, an assessment of differences in ten (10) coping strategies revealed that non-orphans used more wishful thinking than orphan children, although the two (2) groups did not differ significantly in the use of nine (9) other coping strategies. Similarly, the results of the present study is not consistent with a previous study that found gender differences in the use of seven (7) out of the fourteen (14) subscales of the Brief COPE (Lee & Mason, 2014).

Yet, the qualitative aspect of the present study found differences between professionals and family caregivers in the types of coping strategies used. Basically, more professionals (7 out of 10) used rationalisation than family caregivers (1 out of 10) which made rationalisation the most rated form of coping strategy among caregivers. For instance, people who stigmatised

persons with mental illness and their caregivers were perceived to lack understanding of the condition, hence the need for education toward stigma reduction (Gronholm, Henderson, Deb, & Thornicroft, 2017). Again, there were more professionals who used tactical or planned ignoring than there were family caregivers. According to caregivers who used tactical or planned ignoring, not paying attention to the negative attitudes of society helped to avoid negative automatic thoughts that were enough to generate negative feelings and behaviour (McLeod, 2015).

On the other hand, more family caregivers (2) used acceptance than professionals (1). Although previous studies (Cook & Hayes, 2010; Kohl et al., 2013) have noted the effectiveness of acceptance, and indicated how often it was employed (Iseselo et al., 2016), it was not frequently used by caregivers in the present study. Nonetheless, whereas self-motivation was used by only professionals (4), religious coping was mainly employed by family caregivers (6).

Also, religion emerged the most frequently used coping strategy among family caregivers. This implied that family caregivers resort to faith for comfort when faced with unfavourable conditions in their caregiving roles. This is consistent with a previous study that confirmed the prevalence of religious based coping among persons of African origin (Utsey et al., 2004). According to Pearce, Medoff, Lawrence, and Dixon (2016), religious coping plays a significant role for caregivers of persons with severe mental illness. This strategy was identified to yield positive caregiving experiences, although presented with a higher need for mental health education and services. Again, an existing study noted religious coping common among caregivers with higher perception of burden, which generated superior results (Pearce, Singer, & Prigerson, 2006).

In line with the researcher's hypothesis, coping strategies had a significant impact on caregiver wellbeing. The present study found a relationship between the seven coping strategies

of the Brief COPE assessed (i.e. Active Coping, Acceptance, Religion, Emotional Support, Denial, Substance Use, and Self-Blame) and caregiver wellbeing. This finding is consistent with a previous study that mapped a relationship between coping and wellbeing (Kim et al., 2003). Basically, the present study revealed the significant negative impact of self-blame and substance use on caregiver wellbeing. Nevertheless, further analyses showed an increase of these two coping strategies among institutional family caregivers than community family caregivers. Thus, the high use of self-blame and substance use among institutional family caregivers corresponded with their lower wellbeing than community family caregivers.

As verified by Zahn et al. (2015), sentiments of self-blame is typically associated with depressed mood which is linked with excessive distress that typically leads to greater burden of caregiving. For the most part, self-blame is considered a maladaptive form of coping which is emotion focused (Moore, Biegel, & McMahon, 2011), and often generated higher levels of psychological distress, including symptoms of anxiety and depression (Thompson, Mata, Jaeggi, Buschkuhl, Jonides, & Gotlib, 2010). Similarly, there is empirical evidence on the maladaptive nature of substance use, with associated negative impact on psychological quality of life (Vosvick, Gore-Felton, Koopman, Thoresen, Krumboltz, & Spiegel, 2002).

### **5.6 Implications of findings of the Study**

The findings of the present study showed some unfavourable experiences of caregivers of persons with mental illness in community-based mental health care. Although inadequate funding, lack of resources and vital structures, as well as the risk associated with caregiving greatly affected professionals, family caregivers had their fair share of adverse experiences with institutional mental health care, owing to the high cost of admission charges and the cost of frequent travels. Stigma and discrimination were a common challenge for both professionals and family caregivers in CBMH. The effect of the challenges with CBMH on professionals'

wellbeing was more physical, whereas family caregivers had an equal physical and psychological effect. Moreover, the amount of stress and affiliate stigma experienced by community and institutional family caregivers did not differ, even though community family caregivers had a higher wellbeing than institutional family caregivers. Rationalisation was frequently employed by professionals as a strategy to cope with stress, whereas religious coping emerged common among family caregivers. Notwithstanding, caregiver stress and affiliate stigma had an impact on caregiver wellbeing, and a relationship between coping strategies and caregiver wellbeing was proven.

Evidently, there are genuine difficulties associated with CBMH. Despite professionals being the most affected, the wellbeing of family caregivers must be of equal concern. Eventually, the problems noted with INST bothers family caregivers, as evidenced by a lower wellbeing of institutional family caregivers. Pragmatically, persons with mental illness may need institutional care at some point in time, depending on possible changes in condition. Hence, the need to ensure adequate provision of resources for mental health services in general to help safeguard the wellbeing of professionals and family caregivers in Ghana. The practical and theoretical implications of these findings are discussed below.

### **5.6.1 Practical Implications**

In terms of inadequate funding, government must deem it necessary to step up budgetary allocations for mental health services to cater for service requirements and expenses made by mental health professionals in the course of duty. The cost of transport and communication for community services, as well as medications for patients should not be the sole responsibility of mental health professionals. There should be a regular supply of psychotropic medications to assist with the management of persons with mental illness. Better still, government should

consider policy amends to ensure mental health care is fully covered by the national health insurance scheme.

Also, the Ministry of Health, the Mental Health Authority of Ghana, and the Ghana Health service must dedicate attention to ensure the safety of mental health professionals. Occupational health and safety programs targeted at ensuring safety should be instituted and supported. Additionally, there should be compensation and insurance for professionals who get hurt by aggressive patients in line of duty. Moreover, there should be periodic health checks (averagely every 6 months) for both professionals and family caregivers of persons with mental illness to detect and manage any physical or psychological effect of caregiving.

Similarly, there is the need to intensify education on mental health to reduce stigma and discrimination attached to mental illness within by society. The media has a role in promoting mental health and demystifying mental illness among the Ghanaian populace. Furthermore, caregivers should be well informed on more adaptive forms of coping to safeguard their wellbeing.

Nevertheless, caregivers, as well as their practice environments (community and institution) should be equipped with needed resources and structures suitable for the nature of care rendered to reduce risk and burden associated with caregiving. Support for the provision of rehabilitation centres, vocational training centres for persons recovering from mental illness, halfway homes, family caregiver assistance programs, Tele- psychiatry, emergency teams, adequate and right mix of mental health professionals, must be a priority for government. Mental health units or departments should be available in all health facilities across Ghana to ensure easy access to mental health care. Most importantly, there is the need for governmental backing to facilitate the effective implementation of Ghana's mental health act 846 of 2012 to guarantee

the provision of good standards of mental health care that preserves the wellbeing of caregivers and the rights of persons with mental health problems.

### **5.6.2 Theoretical Implications of the Study**

The social model of health (Dahlgren & Whitehead, 1991) which guided the present study maps a relationship between individuals, their environment, and disease. As posited by Modranka and Suchecka (2014), a population's health can be conceptualised by the layers of influence presented by the social model of health (i.e. Peculiar behavioural factors, e.g. smoking habits; social and community influence through interrelations; structural components which include working conditions, access to services and delivery of essential facilities; and an overall mediator of health consisting of economic, cultural and environmental factors). Undoubtedly, the circumstances surrounding community-based mental health care and caregiver experiences has implications for the social model of health.

As per the layers of influence, firstly, the study showed that some personal demographic characteristics of caregivers had an impact on the study variables. Also, the tools used to measure caregiver wellbeing and coping strategies confirmed the impact of some personal lifestyle characteristics on wellbeing. Secondly, affiliate stigma among caregivers was noted to have generated from social and community interactions, in which case was unfavourable to caregivers. Thirdly, the lack of needed resources, poor working conditions, and challenges with access and the delivery of essential mental health services contributed to caregiver stress. Hence, there was an overall neglect from government in ensuring better conditions for the delivery of quality mental health services, necessary to protect the wellbeing of caregivers.

### **5.7 Limitations of the Study and Implications for future Research**

For the purpose of interpretation of discoveries of the present investigation, there are few restrictions worth noting. Although the study aimed to explore the experiences of caregivers in the Eastern Region of Ghana, only caregivers in the New Juaben Municipality were recruited, which constitute a relatively small portion of caregivers in the region. Hence, future studies should explore caregiver experiences across the entire region, or better still, consider a nationwide survey to help identify potential differences in experiences across cultures, and to determine other factors that are peculiar to the ten (10) regions of Ghana.

Again, the use of self-report surveys and one-on-one interviews is commensurate to subjective predispositions, since respondents may have thwarted information, based on desperation, or as a means to avoid embarrassment. Future researchers should therefore envision the exploration of caregiver experiences with a naturalistic approach. This can help deepen the understanding of what caregivers actually go through, and also rule out chances of respondents obstructing information due to desperation or embarrassment.

Nonetheless, the study was conducted using a cross-sectional design. This may have not been enough to gain adequate insight into caregivers' experiences in CBMH in terms of possible fluctuations in experiences over time, as a result of potential changes in patients' condition and circumstances surrounding caregiving. Thus, the researcher missed the opportunity to follow up on caregivers to ascertain trends in their experiences, although the use of a cross-sectional design aided the acquisition of a relatively large sample size within a shorter period of time, which is quite justified in the scope of clinical studies. As a remedy, future researchers should consider a longitudinal study to gain sufficient information about potential trends in caregiver experiences with community-based mental health care.

Additionally, the present study did not examine the types and severity of mental conditions managed, and their potential effects on caregivers. Future studies should deem it necessary to capture such information to broaden the understanding of caregiver experiences. Besides, the experiences of children under the age of eighteen (18) who have assumed caregiver roles by virtue of a mentally ill parent, or assistance given to a parent to care for a mentally ill sibling or relative is worth investigating. Meanwhile, the small effect size (partial eta squared = .02) for observed differences between community and institutional family caregivers on wellbeing may not be realistic or reflect real world differences. Future studies should therefore take note when interpreting the findings.

Notwithstanding all the noted limitations, the present study provides insight into the experiences of mental health professionals and family caregivers of persons with mental illness in the Eastern Region. Findings fill certain gaps in research, and offer a platform for future studies on Ghana's mental health system.

## **5.8 Conclusion**

The effectiveness of Ghana's mental health act 846 of 2012 which directed focus towards CBMH, and deemed to rectify the challenges identified with institutional mental health care has been questioned after six (6) years of passage (Chibaro, 2013). The understanding of caregiver experiences in line with the circumstances surrounding caregiving roles due to inadequate resources, funding, stigma and discrimination needed to be documented. Mixed methods approach was used for the present study. The present study found that CBMH was recognized as an effective model for mental health care. Negative experiences with the model which largely affects professionals, need a critical redress, likewise the challenges identified with INST which largely affects family caregivers. The negative attitude of society (stigma and discrimination) does not only contribute to affiliate stigma, but negatively affect caregiver wellbeing, and also

has a potential to retard patients' recovery. Caregivers would however be able to cope more effectively if more adaptive forms of coping are employed.

It is therefore anticipated that better outcomes in community-based mental health care that substantiates the mandate of Ghana's mental health act (Act 846 of 2012) would materialise, if the legitimate concerns raised by professionals and family caregivers in the present study are duly acknowledged and addressed.

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## APPENDICES

### Appendix I: Ethical Clearance



**UNIVERSITY OF GHANA**  
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

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

My Ref. No.....

1<sup>st</sup> November, 2017

Ms. Akosua Serwaah Bonsu  
Department of Psychology  
University of Ghana  
Legon

Dear Ms. Bonsu,

**ECH 036/17-18: COMMUNITY-BASED MENTAL HEALTH CARE: EXPERIENCES OF PROFESSIONALS AND FAMILY CAREGIVERS IN THE EASTERN REGION**

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

Expiry Date: 31/05/18  
On Agenda for: Initial Submission  
Date of Submission: 18/09/17  
ECH Action: Approved  
Reporting: Quarterly



Please accept my congratulations.

Yours Sincerely,

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

CC: Dr. Maxwell Asumeng, Department of Psychology, University of Ghana.

**Appendix II: Introductory Letter by the Department of Psychology, University of Ghana**



**UNIVERSITY OF GHANA**  
**DEPARTMENT OF PSYCHOLOGY**  
**SCHOOL OF SOCIAL SCIENCES**

Ref. No. PSYC.2/33/01.....

November 16, 2017

The Regional Director of Health Services  
Eastern Region, Ghana

Dear Madam,

**LETTER OF INTRODUCTION**  
**MISS AKOSUA SERWAAH BONSU - ID NO. 10337169**

Akosua Serwaah Bonsu is an MPhil part II Clinical student at the Department of Psychology, University of Ghana, Legon.

In partial fulfillment of the requirement for the awards of the MPhil degree, Miss Akosua Serwaah Bonsu has to write and submit an original thesis.

She has selected the topic: **“Community Based Mental Health Care: Experiences of Professionals and Family Caregivers in the Eastern Region”**.

She has received approval and clearance from the Department of Psychology Graduate Studies Committee and the Ethics Committee of the College of Humanities University of Ghana, Legon.

To enable her collect data for her research work, she would need to administer questionnaires and conduct interviews. She has selected New Juaben Municipality and the Eastern Regional Hospital as suitable for her research.

Any assistance you may give her would be appreciated.

Yours faithfully,

Dr. Maxwell Asuaheng  
(Head of Department)

**COLLEGE OF HUMANITIES**

P. O. Box 1484, Legon, Accra-Ghana

• Telephone: +233 (0) 289 550 463

• Email: [Psychology@ug.edu.gh](mailto:Psychology@ug.edu.gh)

• Website: [www.ug.edu.gh](http://www.ug.edu.gh)

**Appendix III: Study Consent Form**

UNIVERSITY OF GHANA



Official Use only Protocol number
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**Ethics Committee for Humanities (ECH)**

PROTOCOL CONSENT FORM
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Section A- BACKGROUND INFORMATION
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Title of Study:	Community-Based Mental Health Care: Experiences of professionals and Family Caregivers in the Eastern Region.
Principal Investigator:	Akosua Serwaah Bonsu
Certified Protocol Number	

Section B- CONSENT TO PARTICIPATE IN RESEARCH
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**General Information about Research**

This study seeks to explore the in-depth experiences of professionals and family caregivers delivering community-based mental health care. It also aims to determine differences in psychosocial wellbeing of community family caregivers and institutional family caregivers, and to investigate their coping strategies. Outcome of this study will inform policies to improve service delivery. It is anticipated that findings will advise programs to safeguard the wellbeing of professionals and family caregivers. Results of this study will also lay a foundation for future researches on the subject and add to the few studies done on mental health in Ghana.

Individuals who agree to participate in this study are estimated to be engaged for approximately 45 minutes. If you agree to take part in this study, you will be asked to provide

information about yourself, your care role and experiences with caregiving. You will also be asked several questions about community-based mental health care, institutional mental health care, your psychosocial wellbeing and ways of coping. You can choose to read the questionnaire by yourself and provide your responses by ticking on the questionnaire I will hand to you. You can also decide to listen carefully as I read to you and you provide your responses. Freely ask questions if you do not understand any part of the study before agreeing to participate.

### **Benefits/Risks of the study**

You will not receive any benefit directly from this study. However, your involvement will help deepen understanding of what professionals and family caregivers of persons with mental illness go through. Again, your participation will enhance explanation on psychosocial wellbeing of institutional and community-based family caregivers, as well as their strategies for coping. Findings will provide scientific basis to improve community-based mental health service delivery in the Eastern Region, and Ghana. You are assured of no medical procedures that can cause pain or discomfort to you, although you may experience some tiredness while answering questions. You are therefore encouraged to communicate such experiences to me so that we take a short break or continue at a later time. There are no anticipated hazards associated with this study.

### **Confidentiality**

Any information you share during the study will be treated confidential. Your identity will be concealed and your privacy protected during and after the study, hence you will not be traced with your responses. Information you provide can only be accessed by a third party after you have signed or thumb printed a written consent form, or such authorisation given by your representative. Data obtained from this study will only be used for writing a thesis and will form part of published studies on mental health or community-based mental health care. Thus,

students, faculty, health professionals, policy makers, health directors, families, persons living with mental illness, stakeholders and mental health sympathizers may access such publications, but any information that may be used to identify you will not be included in these reports.

### **Compensation**

This study has no funding and is being conducted for academic purposes. Hence you will not receive any financial compensation. However, you will be given a pen after the study to compensate for your time spent in answering questions.

### **Withdrawal from Study**

Your participation in this study is voluntary, and you may withdraw at any time without being penalized. You will not be affected negatively if you decide to withdraw before or during the study. You are assured that either you or your legal representative will be informed on time should any information relevant to your willingness to continue participating in the study or withdraw becomes available. However, your participation may be discontinued if information you gave to meet the study's inclusion criteria is false. Also, your participation may be terminated if your health condition at the time of the study does not permit your engagement.

### **Contact for Additional Information**

You are encouraged to direct questions, and complains about unfortunate injuries related to this study to Akosua Serwaah Bonsu, Box 201, Koforidua. Contact: +223(0)244014348, email: [akosuasbonsu@yahoo.com](mailto:akosuasbonsu@yahoo.com). Besides, if you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at [ech@isser.edu.gh](mailto:ech@isser.edu.gh) / [ech@ug.edu.gh](mailto:ech@ug.edu.gh) or 00233- 303-933-866.

Section C- PARTICIPANT AGREEMENT

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

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Signature or mark of Participant

\_\_\_\_\_  
Date

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

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

\_\_\_\_\_  
Name of witness

\_\_\_\_\_  
Signature of witness / Mark

\_\_\_\_\_  
Date

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

Akosua Serwaah Bonsu

Name of Person who Obtained Consent

\_\_\_\_\_  
Signature of Person Who Obtained Consent

13<sup>th</sup> September, 2017

\_\_\_\_\_  
Date

**Appendix IV: Qualitative Interview Guide****A. *Demographic information***

1. Gender (interviewer to indicate sex of participant)
2. How old are you?
3. Care role (interviewer to indicate if participant is a professional or a family caregiver)
4. What is your relationship with patient (family caregivers only)
5. How long have you been caring for a person(s) with mental health problems?
6. Are you married?
7. What is your highest level of education?
8. What religion are you affiliated to?
9. What work do you do? (interviewer to inquire if participant earns some income)

**B. *Community-based mental health care***

1. What are your views about community-based mental health care?
  - a. How is it helpful to you?
  - b. What are your challenges?
2. What in your opinion are ways of improving community-based care?
3. What are your views on the shift from institutional to community-based care?
- 4a. Between institutional and community-based care, which will you prefer?
- 4b. In your opinion, what are the challenges with institutional mental health care?

**C. *Impact of caring***

5. Which of the two models of mental health care is more stressful and why? (professionals)
6. How does community-based care affect your finances, career, daily activities, and well-being?

7. How does society relate with caregivers and persons with mental health problems? How does it affect you?
8. What strategies do you employ as means of coping?

We have come to end of the interview. Is there anything else you would like to discuss that we haven't mentioned yet? Do you have any questions for me? (If not) Thank you very much for your time.

**Appendix V: Demographic Questionnaire for Quantitative aspect**

**(1) Sex:**  Male

Female

**(2) Age:** .....

**(3) No of years as a carer:** .....

**(4) Relationship with patient:** .....

**(5) Highest Level of Education:**

No formal Education

Primary - JHS

O/A Level/ SSCE

Diploma

Degree

Post-Graduate

**(6) Religious affiliation:**  Muslim

Christian

Traditional

Other.....

**(7) Marital Status:**  Single

Married

Divorced

Widow/Widower

Separated

**(8) Income status per month:**

None

GHc1.00 – GHc300

GHc300.00 – GHc500.00

GHc500.00 – GHc1, 000.00

GHc1, 000.00 and above

**(9) Family caregiver status:**  Community  Institutional







	makes me think that I am lesser to others.				
14	Having a family member with mental illness/intellectual disability makes me lose face.				
15	I avoid communicating with _____ (name of family member with mental illness/intellectual disability).				
16	I dare not to tell others that I have a family member with mental illness/intellectual disability.				
17	I reduce going out with _____ (name of family member with mental illness/intellectual disability).				
18	Given that I have a family member with mental illness/intellectual disability, I've cut down the contacts with my friends and relatives.				
19	When I am with _____ (name of family member with mental illness/intellectual disability), I would keep an especially low profile.				
20	I've cut down the contacts with _____ (name of family member with mental illness/intellectual disability).				
21	I dare not to participate in activities related to mental illness/intellectual disability lest other people would suspect that I have a family member with mental illness/intellectual disability.				
22	Given that I have a family member with mental illness/intellectual disability, I've cut down the contacts with my neighbors.				

**D. *The Brief COPE (Carver, 1997)***

*Please put a check mark (✓) under the number that best corresponds to the degree to which you have been performing the following as your way of coping with stress associated with care-giving.*

1= I usually don't do this at all

3 = I usually do this a medium amount

2 = I usually do this a little bit

4 = I usually do this a lot

		1	2	3	4
1	I've been concentrating my efforts on doing something about the situation I'm in.				
2	I've been taking action to try to make the situation better.				
3	I've been accepting the reality of the fact that it has happened.				
4	I've been trying to live with it.				
5	I've been trying to find comfort in my religion or spiritual beliefs.				
6	I've been praying or meditating.				
7	I've been getting emotional support from others.				
8	I've been getting comfort and understanding from someone.				
9	I've been saying to myself "this isn't real"				
10	I've been refusing to believe that it has happened.				
11	I've been using alcohol or other drugs to make myself feel better.				
12	I've been using alcohol or other drugs to help me get through it.				
13	I've been criticizing myself.				
14	I've been blaming myself for things that happened.				