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Psychological distress among community-based mental health professionals in Ghana: prevalence and contributing factors

Akosua Serwaah Bonsu[1] · Joana Salifu Yendork[1] · Kwaku Oppong Asante[1,2] · Enoch John Dotse[1] · Kenneth Owusu Ansah[1]

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Abstract
In Ghana, community-based mental health professionals (MHPs) are essential in providing mental health treatments, albeit in difficult circumstances. High workloads, a lack of institutional support, and resource constraints are among the factors in these professions' elevated psychological distress. Using a sequential explanatory mixed methods design, this study investigated the prevalence and contributing factors of psychological distress among mental health professionals (MHPs) working in communities in Ghana. Using the DASS-21 scale, quantitative data were gathered from 300 MHPs, and the results showed that the prevalence of clinically significant levels of psychological distress (from mild to extremely severe) was 41.3% for anxiety, 36% for depression, and 32.7% for stress. Psychological distress was significantly influenced by factors such as marital status and work experience. Qualitative interviews with 25 MHPs revealed more stressors that support the high prevalence rates, including workload and clients' behaviour; resource and infrastructure constraints; stigma and affiliate stigma; and lack of institutional support and isolation. The nature and extent of distress beyond depression, anxiety and stress gathered from MHPs' perspectives were the experience of "intense distress" (acute), "persistent distress" (chronic), and "emotional distress" (a component of burnout). Therefore, systemic adjustments, including better infrastructure, more financing for mental health services, and the creation of MHP-specific support programmes, are needed to address the psychological distress of MHPs in Ghana.

Keywords Psychological distress · Prevalence of distress · Contributing factors · Community-based mental health professionals

1 Introduction

State of anxiety, depression, and stress defines psychological distress which frequently originates from work or life stressors [1]. Psychological distress happens when the stressors someone faces surpass their ability to cope effectively [2]. Workers in emotionally demanding professions including MHPs experience higher distress levels because they encounter patient trauma and psychological pain [3, 4]. The combination of emotional demands results in harmful consequences for both work and personal aspects of life through lower job satisfaction levels and reduced functionality, which can lead to burnout [5]. MHPs can show various emotional, cognitive and physical signs including persistent depressive or irritable feelings, problems with concentration and decision making and memory issues along with headaches, fatigue, muscle

✉ Joana Salifu Yendork, jyendork@ug.edu.gh; salifujoana@gmail.com | [1]Department of Psychology, University of Ghana, Legon, Accra, Ghana. [2]Department of Psychology, University of the Free State, Bloemfontein, South Africa.

tension and sleep disturbances [5]. The body's constant adjustments to stressful situations and emotional demands result in the symptoms of chronic stress.

Mental health professionals (MHPs) experience psychological distress from various job-related stressors such as handling many cases and limited resources along with administrative duties while witnessing patient distress and treating severe mental health problems [3, 6]. Their experience translates to burnout along with feelings of irritation and powerlessness which fosters cynicism and negatively affects their emotional health and quality of service delivery [4, 5]. When professionals experience psychological distress they demonstrate less empathy which creates barriers to forming therapeutic connections with their clients [7]. MHPs' difficulty in delivering the required understanding and emotional support leads to lower-quality care. Those who suffer from compassion fatigue will emotionally detach from their clients which undermines the effectiveness of mental health care [8]. Practising medicine while experiencing psychological distress leads MHPs to perform less effectively at work and they become more prone to taking leave and making errors [9].

Mental health professionals dedicate their lives to ensuring the well-being of people suffering from mental disorders and as a result, incur some form of stress, anxiety, and depression themselves [10, 11]. A meta-analysis of data shows that psychological distress was reported by 31–52% of health professionals, especially those working in poorly supported environments [3]. These findings are especially worrisome in low-resource settings, from which these LMICs suffer greatly from not having enough mental health resources, support for MHPs, and quality infrastructure [6, 12]. Data gathered from low and middle-income countries, particularly Ghana, show that MHPs work in a state of psychological distress, especially in community contexts [6, 13, 14]. In these environments, MHPs are expected to serve sizable, underserved populations with limited resources, and mental health care is frequently underfunded. They have limited chances for professional growth, lack support facilities, and operate on their own with little supervision [15]. Among the barriers to care in such communities are working in remote or rural settings, poor mental health infrastructure, long distances to travel, and poor roads [15]. For patients with serious and persistent mental health issues, especially those who have been subjected to abuse, neglect, or trauma, MHPs working in the community are frequently the initial point of contact because of their proximity to them [16]. In effect, community-based MHPs not only face and need to manage the mental health needs of individuals but also have the pressure of handling larger social and economic issues, amidst the negative effects of inadequate supervision and peer support, [17] which may lead to secondary traumatic stress disorder (STS) and post-traumatic stress disorder (PTSD). The absence of sufficient direction or support might worsen emotional distress among professionals, who find it difficult to handle the psychological and administrative responsibilities of their jobs [5].

Existing literature has highlighted stressors that may contribute to distress specifically among Community-based MHPs in Ghana [13, 14], but little is known about the extent of distress in other MHPs. More so, the nature of the direct impact on MHPs is unclear [12, 15], including how their demographic factors influence the levels of potential distress among them. Besides, existing studies outside the Ghanaian context [18–20] have used a quantitative method, hence, a description of distress, beyond depression, anxiety and stress [21–23] experienced by MHPs from their own perspectives is unclear. Therefore, there is the need for a study that employ a mixed-method approach, highlighting the nature and extent of distress, beyond depression, anxiety and stress, in addition to triggers experienced by MHPs from their perspectives. This study seeks to understand how the nature and extent of psychological distress amongst MHPs in community settings in Ghana is manifested and what contributes to it using mixed methods.

2 Method

2.1 Research design

The current study used a sequential explanatory mixed methods design, as quantitative data were first gathered and analysed to inform the sample for the collection and analysis of qualitative data [24]. Hence, quantitative data on psychological distress among MHPs were gathered and evaluated, and then qualitative data was taken from participants who indicated medium to high levels of psychological distress [25].

2.2 Participants and procedure

According to Ghana Health Service [26], approximately 592 Registered Mental Health Nurses (RMNs) and Community Mental Health Officers (CMHOs) work in the Eastern and Ashanti Regions of Ghana. Three hundred (300) of the RMNs and CMHOs were thus, purposefully and conveniently sampled to participate in the quantitative phase. This sample size

was calculated using Krejcie and Morgan's [27] formulae, which state that a sample size of 300 is acceptable for a target population of 592. Additionally, the 300 participants were sampled for the study based on G-Power (version 3.0.10) software by Faul et al. [28], which asserts that a minimum sample size of 213 will be adequate for multivariate analysis of variance with a 0.05 significance level and a medium effect size (0.5) based analysis. Participants were selected from regional and district hospitals, as well as health centres. 162 and 138 were recruited from the Eastern and Ashanti Regions of Ghana respectively. To ensure data quality, consistency and ethical compliance, two research assistants were recruited and trained in the data collection process. The training covered an understanding of the research objectives, familiarity with the Google Forms platform, handling of participants' questions and answers, and data quality assurance.

From this, 25 participants who reported moderate to high levels of psychological distress were purposively sampled to participate in the qualitative phase of the study based on Malterud et al. [29] idea of information power. Participants for the present study were either men or women over eighteen years old who were employed full-time and had at least a year's worth of job experience. Participants were healthcare professionals in Ghana's Ashanti and Eastern Regions who worked in mental health units inside general healthcare settings. According to Malterud et al. [29], the participants' active involvement in providing community-based mental health care meant they had the requisite knowledge power. The quantitative survey on demographic variables, depression, anxiety, and stress was conducted using Google Forms and spanned over 8 weeks (i.e. from 20th June to 15th August 2013). Individual in-depth interviews for the qualitative aspect of the study were conducted in person in a private area during MHPs' free time at work, each lasting approximately 60 min. Qualitative data collection lasted for 8 weeks (i.e. 4th September to 23rd October 2023).

The distribution of participants across all demographic characteristics in the study is displayed in Table 1. The chart shows that of the 300 participants, 171 (57%) were female and 129 (43%) were male. The participants' ages ranged from 23 to 51 years, with a mean age of 34. Further demographic information can be found in Table 1.

Personal information of participants in the qualitative phase are illustrated in Table 2. The participants' ages ranged from 26 to 47 years, with 34 being the average age. There were somewhat more men (14 [56%]) than women (11 [44%]), with 13 (52%) being married, 11 (44%) being single, and 1 (4%) being divorced. While some participants (11 [44%]) had no children, the majority (14 [56%]) had at least one. Further demographic information can be found in Table 2.

Table 1 Demographic characteristics of mental health professionals in the quantitative study

Variables	Category	Mental health professionals			
		Frequency (%)	M	SD	Range
Age		300	34.04	5.03	23–51
Number of years worked		300	7.47	4.71	1–23
Number of children		300	1.33	1.263	0–5
Sex	Male	129 (43%)			
	Female	171 (57%)			
Type of mental health professional	RMN	257 (85.7%)			
	CMHO	43 (14.3%)			
Grade of professional	Senior	225 (75%)			
	Junior	75 (25%)			
Highest level of education	Diploma	186 (62%)			
	Degree	97 (32.3%)			
	Post-graduate	17 (5.7%)			
Religious affiliation	Muslim	7 (2.3%)			
	Christian	287 (95.7%)			
	Traditional	3 (1%)			
	Other	3 (1%)			
Marital status	Single	109 (36.3%)			
	Married	181 (60.3%)			
	Divorced	6 (2%)			
	Widow/widower	1 (0.3%)			
	Separated	3 (1%)			

2.3 Measures

2.3.1 Demographic questionnaire

Participants' demographic data included age, gender, marital status, number of children, current health issue, category of mental health professional (e.g., RMN or CMHO), rank, socioeconomic status, number of years worked, religion, and greatest degree of education.

2.3.2 Depression, anxiety, and stress scale (DASS-21, Lovibond & Lovibond, 1995)

Psychological distress was assessed using DASS-21 which has three subscales: "Depression," "Anxiety," and "Stress." Depression subscale evaluates hopelessness, dysphoria, apathy, anhedonia, self-deprecation, devaluation of life, and inertia. The stress subscale evaluates impatience, being easily upset, irritable or over-reactive, difficulty relaxing, and nervous arousal. The anxiety subscale evaluates the subjective experience of the anxious response, autonomic arousal, skeletal muscle effects, and situational anxiety [30]. For the overall score, the sum of the scores for each subscale is multiplied by two. The depression subscale has a total score range of 0–42, where 0–9 represents normal, 10–13 represents mild, 14–20 represents moderate, 21–27 represents severe, and 28 and beyond represents extremely severe depression. For the anxiety subscale, a score of 0–7 denotes normalcy, a score of 8–9 for mild anxiety, a score of 10–14 for moderate anxiety, a score of 15–19 for severe anxiety, and a score of 20 or higher for extremely severe anxiety. The stress subscale scores range from 0 to 14 which indicates normal stress, 15–18 which is light, 19–25 which is moderate, 26–33 which is severe, and 34 and higher which indicates extremely severe stress. Lovibond and Lovibond [30] suggest higher scores indicate the presence or high levels of psychological distress, whereas lower values indicate the absence or low levels of psychological distress. The DASS-21 scale's overall Cronbach's alpha was 0.95, while depression, anxiety, and stress had respective Cronbach's alphas of 0.93, 0.85, and 0.90 [31]. This scale is valid and reliable in Ghana [32] and the current study found Cronbach's alphas for stress (0.91); anxiety (0.84); and depression (0.87).

Table 2 Demographic characteristics of mental health professionals in the qualitative study

Variables	Category	Range	Frequency (%)
Age		26–47 years	
Sex	Male		14 (56%)
	Female		11 (14%)
Marital status	Single		11 (44%)
	Married		13 (52%)
	Divorced		1 (4%)
Number of children		0	11 (44%)
		1–5 children	14 (56%)
Health status	Existing health conditions		2 (8%)
	No existing health conditions		23 (92%)
Years of working experience		1–3 years	7 (28%)
		4–14 years	18 (72%)
Religious affiliation	Christians		25 (100%)
Highest level of education	Diploma		12 (48%)
	Degree		11 (44%)
	Masters		2 (8%)
Category	RMN		23 (92%)
	CMHO		2 (8%)
Rank	Senior		18 (72%)
	Junior		7 (28%)

RMN Registered Mental Health Nurse, *CMHO* Community Mental Health Officer

2.4 Semi-structured interview schedule

The study team devised a semi-structured interview guide to help collect participants' perspectives on psychological distress and contributing factors. The format of the questions was open-ended to encourage talks about the experiences of professionals (e.g., *"Have you been feeling any psychological distress symptoms? Describe in detail*) and explanations of the causes (e.g., *"What factors account for your distress symptoms?"*).

2.5 Ethical considerations

The authors' university granted ethical permission before any data were collected. All participants gave informed consent and participation was completely voluntary. The confidentiality and anonymity of participants' responses were guaranteed, and the data was cleansed of identifying information to preserve privacy. To mitigate potential distress, participants were furnished with details regarding mental health support resources that are accessible if they encounter discomfort during or following the study. The data were utilised exclusively for this study, were safely stored, and were only accessible by the research team.

2.6 Data analysis

Descriptive statistics, Pearson Product moment correlation**,** multivariate analysis of variance (MANOVA), which was followed by univariate ANOVAs, and multiple regression analysis were conducted using SPSS version 27 to assess psychological distress quantitatively. Information transcribed from interviews was subjected to Braun and Clarke's [33] six-step qualitative thematic analysis to identify and interpret patterns, which included data familiarization, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report. Credibility through member checking, and peer debriefing; dependability through audit trail; confirmability through reflexivity and participant quotes; transferability through thick descriptions of participant experiences and context assured the quality of this study [34].

3 Results

3.1 Quantitative results

3.1.1 Preliminary analysis

To confirm normality, the skewness and kurtosis of the scores acquired for the study's variables were analysed. The skewness and kurtosis, as indicated by Table 3, fall between − 0.29 and + 2.48. In line with Garson's [35] recommendation, the current data is normally distributed because the kurtosis and skewness are equal to or less than three (3).

The inter-correlation matrix which indicates the relationships among the study variables was analysed using the Pearson product moment correlation and the results are presented in Table 4. There is a high correlation between depression, anxiety and stress. Tabachnick and Fidell [36] assert that in testing for multivariate analysis of variance, one needs to ensure linearity between the various dependent variables and this assumption was met in this study. The table further indicated that the correlation coefficient for the dependent variables to be used for multivariate analysis was within 0.80. Additionally, the correlation coefficient for the various independent variables used for the regression analysis was within 0.70. Therefore, there was no violation of multicollinearity [36].

Table 3 Mean, standard deviation, Cronbach's alpha, skewness and kurtosis for the study variables (n = 300)

	Mean	SD	Min	Max	Skewness	Kurtosis	Alpha
Stress	5.67	5.31	0.00	21.00	0.81	− 0.29	0.91
Anxiety	3.90	4.15	0.00	21.00	1.35	1.89	0.84
Depression	3.82	4.30	0.00	21.00	1.50	2.48	0.87

Table 4 Intercorrelation matrix for depression, anxiety and stress

	1	2	3	4	5	6
1. Stress	–					
2. Anxiety	0.77***	–				
3. Depression	79***	0.79***	–			
4. Age	0.024	−0.01	0.01	–		
5. YWE	0.083	0.024	0.05	0.73***	–	
6. NOC	0.019	0.04	0.02	0.44**	0.44**	–

YWE years of work experience, *NOC* number of children

**Correlation significant at the 0.01 level

***Correlation significant at the 0.001 level

3.1.2 Prevalence of psychological distress

Psychological distress that is severe enough to interfere with day-to-day functioning and necessitates attention or intervention is referred to as clinically significant and the threshold for clinical relevance varies based on the diagnostic instrument. Clinically severe symptoms are often indicated by DASS-21 scores of 10+ for depression, 8+ for anxiety, and 15+ for stress [30]. Hence, the prevalence of clinically significant levels of psychological distress among MHPs in the present study was 32.7% for stress, 41.3% for anxiety, and 36% for depression (see Table 5). The findings suggest that a significant portion of MHPs experience elevated levels of psychological distress.

3.1.3 Multivariate analysis

A Multivariate Analysis of Variance (MANOVA) was conducted to examine the effect of gender, professional category, rank, level of education, marital status and religion on psychological distress, specifically depression, anxiety, and stress, among MHPs (Table 6). The results of the MANOVA indicated that there was no significant multivariate effect of gender on psychological distress, Wilks' Lambda = 0.987, $F(3, 248) = 1.055$, $p = 0.369$, partial $\eta^2 = 0.013$, professional category on psychological distress, Wilks' Lambda = 0.984, $F(3, 248) = 1.328$, $p = 0.266$, partial $\eta^2 = 0.016$, rank on psychological distress, Wilks' Lambda = 0.984, $F(3, 248) = 1.344$, $p = 0.261$, partial $\eta^2 = 0.016$, level of education on psychological distress, Wilks' Lambda = 0.969, $F(6, 496) = 1.326$, $p = 0.244$, partial $\eta^2 = 0.016$, and religion on psychological distress, Wilks' Lambda = 0.972, $F(9, 603.72) = 0.787$, $p = 0.629$, partial $\eta^2 = 0.009$. However, there was a significant multivariate effect of marital status on psychological distress, Wilks' Lambda = 0.913, $F(12, 656.44) = 1.328$, $p = 0.031$, partial $\eta^2 = 0.030$.

Table 5 Prevalence of psychological distress among mental health professionals

Variable	Category	Prevalence	Proportion [95% CI]	Cut-off score
Stress	Normal	202 (67.3%)	0.67 [0.62, 0.72]	0–14
	Mild stress	26 (8.7%)	0.09 [0.06, 0.12]	15–18
	Moderate stress	30 (10%)	0.1 [0.07, 0.14]	19–25
	Severe stress	33 (11%)	0.11 [0.08, 0.15]	26–33
	Extremely severe stress	9 (3%)	0.03 [0.02, 0.06]	34 and above
Anxiety	Normal	176 (58.7%)	0.59 [0.53, 0.64]	0–7
	Mild anxiety	12 (4%)	0.04 [0.02, 0.07]	8–9
	Moderate anxiety	58 (19.3%)	0.19 [0.15, 0.24]	10–14
	Severe anxiety	21 (7%)	0.07 [0.05, 0.11]	15–19
	Extremely severe anxiety	33 (11%)	0.11 [0.08, 0.15]	20 and above
Depression	Normal	192 (64%)	0.64 [0.58, 0.69]	0–9
	Mild depression	37 (12.3%)	0.12 [0.09, 0.17]	10–13
	Moderate depression	48 (16%)	0.16 [0.12, 0.21]	14–20
	Severe depression	9 (3%)	0.03 [0.02, 0.06]	21–27
	Extremely severe depression	14 (4.7%)	0.05 [0.03, 0.08]	28 and above

Table 6 Multivariate effects of sociodemographic variables on psychological distress

	Wilk's Lambda	F	df	p	Partial η^2
Gender	0.99	1.01	3, 248	0.369	0.01
Professional category	0.98	1.33	3, 248	0.266	0.016
Rank	0.98	1.34	3, 248	0.261	0.016
Level of education	0.97	1.33	6, 496	0.244	0.016
Religion	0.97	0.79	9, 603.72	0.787	0.009
Marital status	0.91	1.33	12, 656.44	0.031	0.030

Follow-up univariate ANOVAs showed a significant effect of marital status on both anxiety, $F(4, 54.60) = 3.14$, $p = 0.015$, partial $\eta^2 = 0.048$, and depression, $F(4, 69) = 3.62$, $p = 0.007$, partial $\eta^2 = 0.055$. There was no significant effect of marital status on stress, $F(4, 69.91) = 2.46$, $p = 0.056$, partial $\eta^2 = 0.028$. Post hoc comparisons using the Tukey HSD test revealed that widowed MHPs had significantly higher levels of anxiety ($M = 10.00$, $SD = 2.83$) compared to their single ($M = 3.87$, $SD = 4.17$) and married counterparts ($M = 3.76$, $SD = 4.07$). It was further observed that the widowed MHPs had significantly higher levels of depression ($M = 12.50$, $SD = 6.36$) compared to their single ($M = 3.86$, $SD = 4.51$) and married counterparts ($M = 3.62$, $SD = 4.07$). The findings are reported in Table 7.

3.1.4 Regression analysis

A multiple regression analysis was conducted to examine whether age, number of years of work, and parity could significantly predict psychological distress (depression, anxiety, and stress) among mental health professionals. The results indicated that only the number of years of work significantly predicted stress, $\beta = 0.21$, $t(300) = -0.12$, $p < 0.05$, accounting for 1.4% of the variance in stress levels, $R^2 = 0.014$. Neither age nor parity significantly predicted stress, depression, or anxiety (all $p > 0.05$). This suggests that as the number of years of work increases, stress levels also increase, while age and parity do not have a meaningful impact on psychological distress in this sample. The findings are reported in Table 8.

3.2 Qualitative findings

Two main themes regarding the experience of emotional stress and anxiety and factors perceived to be responsible for the distress are reported.

Table 7 Univariate ANOVA results for marital status on anxiety, depression and stress

	F	df	p	Partial η^2	Post hoc comparisons (Tukey HSD)
Stress	2.46	4, 69.91	0.056	0.028	No significant differences
Anxiety	3.14	4, 54.60	0.015	0.048	Widowed > single, married
Depression	3.62	4, 69	0.007	0.055	Widowed > single, married

Table 8 Multiple regression predicting psychological distress from age, number of years of work and number of children

Dependent variable	Predictor	B	SEB	β	t	p	R^2
Stress	Age	−0.15	0.11	−0.15	−1.38	0.169	0.014
	Years of work	0.23	0.12	0.21	1.97	0.049	
	Number of children	−0.03	0.27	−0.01	−0.12	0.906	
Anxiety	Age	−0.08	0.09	−0.09	−0.88	0.378	0.004
	Years of work	0.08	0.09	0.09	0.80	0.424	
	Number of children	0.13	0.21	0.04	0.61	0.542	
Depression	Age	−0.10	0.09	−0.12	−1.13	0.260	0.007
	Years of work	0.13	0.10	0.15	1.39	0.166	
	Number of children	0.03	0.22	0.01	0.15	0.884	

3.2.1 Experiencing emotional stress and anxiety

In varied degrees, many participants expressed psychological distress which they directly related to the nature of their work. While some reported experiencing intense distress (acute) during some particular work-related events or times, others spoke of persistent distress (chronic), and emotional distress (component of burnout).

3.2.2 Key contributors to psychological distress

Investigating the perceived causes of psychological discomfort in MHPs was the study's second goal. Several sub-themes that highlighted the role of both systemic and individual factors in distress emerged. Details of qualitative findings are presented in the Table 9.

4 Discussion of findings

This study investigates the prevalence of psychological distress and its related factors among MHPs working in the community in Ghana. The results reveal that a noteworthy segment of MHPs undergoes diverse degrees of psychological distress, with certain demographic characteristics playing a role. Qualitative findings also revealed several factors that are perceived to be associated with the experienced distress.

4.1 Quantitative findings

According to the study's quantitative results, anxiety was the most prevalent psychological distress with 41.3% of individuals reporting having it and was followed by depression (36%), then stress (32.7%). These results are in line with previous studies that show MHPs frequently endure high levels of psychological discomfort as a result of their line of work [37]. Hence, targeted treatments are desperately needed to address mental health concerns among MHPs in Ghana. The study's findings about the levels of psychological distress may be explained by the difficult nature of mental health work in community settings, where MHPs frequently deal with resource limitations and difficult client behaviour. Previous research has demonstrated that high patient loads and a lack of support networks put healthcare professionals in resource-constrained environments at higher risk of burnout and psychological distress [38]. The discovery that 41.3% of MHPs report feeling anxious highlights how crucial it is to give MHPs operating in these kinds of settings enough resources and support.

The study also discovered that sociodemographic variables, specifically years of work experience and marital status, had a substantial impact on psychological distress. Those who were widowed reported feeling more depressed and anxious than those who were married or single. This result is in line with research indicating widowed individuals are more susceptible to psychological discomfort as a result of the social and emotional effects of losing a spouse (such as social isolation, stigmatisation, grief and anxiety) [39]. The added emotional load that widowed MHPs bear in addition to the demands of their professional responsibilities may be the cause of their higher distress levels. Furthermore, MHPs with longer work histories expressed greater stress. This could result from extended exposure to work-related stressors, like managing challenging clients, having insufficient resources, and the emotional strain of delivering mental health treatment over an extended period [11]. These results imply that to lessen the long-term consequences of work-related stress, more seasoned MHPs could need customised interventions.

4.2 Qualitative insights into contributing factors

The study's qualitative phase yielded more insights into the particular reasons accounting for the psychological distress levels in MHPs. The workload and behaviour of the clients, stigma and affiliate stigma, the low regard for mental health, the dangers of moving around the community and inadequate resources, as well as the absence of institutional support, are some of the major factors reported.

For workload and clients' behaviour, particularly in outpatient settings, many participants expressed feeling overburdened by the volume of clients they were required to care for. This result is consistent with studies showing that stressful

Table 9 Summary of qualitative findings

Theme	Sub-theme	Description	Supporting quotes
Experiencing emotional stress and anxiety	Intense distress	Participants reported feeling overwhelmed with various physical symptoms due to frustration associated with inadequate resources and managing aggression with limited support	I do get very tired of chasing the resources I need to work with. For instance, there are times that I have to comb various departments in search of medications to help me calm patients during emergencies but to no avail. My unit has only one male practitioner among several females so I experience muscular tension after managing physical aggression or running errands. Headaches are very common anytime I engage with patients for longer hours. I'm depressed now because I keep worrying and getting frustrated about resource unavailability. I get discouraged very much because every effort I put in to help the system run proves futile. I get irritated a lot and it happens when resources to work with are not forthcoming [RMN31, 45 years, female, 14 years working experience]
	Persistent distress	Frequent resource challenges which seemed to be a component of participants' work were associated with worries and anxieties	I think and worry a lot about not being able to help my patients get their medicines. They don't even have money to purchase them from outside, yet, there is little I can do since I am not the in-charge here. The truth is, I find it difficult to cope when patients are unable to access their medicines. Besides, I'm quite new in the profession and so I become anxious sometimes when I have to attend to aggressive patients [CMHO32, 35 years, male, 1-year working experience]
	Emotional distress	Aside from worrying about resource challenges and the inability to meet expected patients' care needs, professionals perceived a risk to their health due to the impact of work-related challenges	I'm a mental health nurse all right, but I'm not immune to mental disorders, which means that I can break down psychologically with a condition like depression while experiencing all this stress. I also risk developing other physical conditions like hypertension. Patients are beating us up during their aggressive episodes due to limited workspace and resources. It's like within two minutes I'm already exhausted, and it's all about the working environment [RMN8, 29 years, male, 3 years working experience]
Key contributors to psychological distress	Workload and clients' behaviour	Participants frequently found it difficult to provide the same level of focus and attention when the number of patients rises, which can cause stress and feelings of inadequacy	Aww [lamenting]…sometimes patients' behaviour and the increased number of patients I see especially on an OPD basis is unbearable, which limits my ability to offer quality care [RMN5, 36 years, male, 8 years working experience]
	Stigma and affiliate stigma	MHPs experience isolation as they are often solely responsible for the care of persons with mental illness due to fear and misunderstanding among general health professionals. This situation increases their workload, forces them to work beyond normal hours, and creates emotional stress. This sense of obligation to sacrifice personal time highlights the emotional toll of this stigma	Even though we are all health professionals, those who are not mental health staff stigmatise me and the patients I care for. I am often called from home even at night to administer medicines to "my patients" who are on admission because the general health nurses are afraid of them regardless of the type of mental health condition. If I don't come to serve the medications myself, I will come to realise the next day that it wasn't served, so I always sacrifice to come and also make sure the patient has eaten and is comfortable before I leave [RMN16, 27 years, male, 2 years working experience]

Table 9 (continued)

Theme	Sub-theme	Description	Supporting quotes
	Poor perception of mental health	In addition to having an impact on patients, a hesitation to seek mental health care due to a pervasive misperception about mental health problems puts MHPs under more stress, even with attempts to establish rapport with prospective clients	In this community, most patients do not come for mental health reviews because they perceive mental illness as a physical condition like malaria or typhoid and would rather see medical personnel or not come to the hospital at all… [RMN17, 30 years, male, 2 years working experience]
	Dangers of moving around the community and inadequate resources	The delivery of mental health care in distant communities, and the absence of basic amenities pose several logistical problems and dangers, which could make MHPs feel powerless and frustrated	This is a hard-to-reach community and it is very difficult to move from my current location to visit patients in the other communities. The roads are very bad and there is a river to cross to get to the other communities which overflows its banks during the rainy season [RMN19, 33 years, male, 7 years working experience]
	Lack of institutional support and isolation	Feelings of being overburdened and abandoned are common among MHPs who operate alone and receive inadequate support and resources from their healthcare institutions	My biggest challenge is working alone. I am the only mental health nurse in this facility and sometimes I just need a second opinion or a helping hand with my work. However, I always have to plan and do everything on my own… Another challenge has to do with inadequate financial support to conduct outreach services in the community or support other mental health units in the district as a coordinator and sometimes have to use my own money to cater for transport costs." [RMN282, 31 years, female, 8 years working experience]

patient encounters and a high caseload are major sources of stress for healthcare professionals [40]. When MHPs are faced with time and resource constraints that prevent them from providing quality care, it might worsen psychological distress because they feel inadequate in meeting their patients' requirements.

Regarding stigma and affiliate stigma, distress was also significantly exacerbated by the stigma associated with mental health, which exists both in the general public and within the healthcare system. MHPs reported feeling isolated in their workplaces and stigmatised by their co-workers. Research has indicated that internalising the stigma around mental health by healthcare workers, known as affiliate stigma, can lead to feelings of inadequacy and distress in the profession [41].

Concerning poor perception of mental health, the study discovered that poor health-seeking behaviour and a lack of support for mental health services resulted from the widespread ignorance of mental health issues in many communities. This is in line with research from other low- and middle-income nations, where there is a lack of knowledge about mental health issues and cultural norms frequently make it difficult to treat mental health issues effectively [42]. MHPs that operate in these settings encounter further difficulties in their efforts to inform and involve communities in mental health services.

Risks and difficulties with movement were the result of poor road infrastructure and dangerous travel conditions faced by MHPs while trying to reach patients in the community. This finding is consistent with the work of Ofori-Atta et al. [43] who emphasised the dangers that community-based mental health work poses to professionals in Ghana, where there is a dearth of infrastructure. Bad roads, long distances to travel, and unsafe transportation contribute to delays, fatigue, and reduced service coverage in rural or underserved areas [44, 45]. Professionals are further discouraged from working in remote locations due to these challenges, which worsen the disparities in mental health service accessibility [46]. More so, limited resources were often cited as contributing factors to psychological distress, such as inadequate physical space and a shortage of necessary health supplies. This research points to larger issues in low-resource environments, where mental health facilities are frequently underfunded and ill-equipped [47]. The provision of care is hampered by insufficient resources, which also makes MHPs more stressed. Health policies need to focus on infrastructure development, safe transport, and integration of telehealth in addition to providing hardship allowances and logistical support [48].

On the issue of institutional support and isolation, poor institutional support, such as operating as a lone MHP in a facility or lack of finances to support outreach programmes, further contributed to psychological distress. The finding agrees with the broader system-wide issues of low-resourced mental health service delivery, where practitioners are often not given the necessary support because of underfunding and lack of coordination [49]. The incompetence of the health workforce is facilitated by burnout, job dissatisfaction, and low commitment to life and critical care due to poor institutional support and professional isolation [50]. Poor institutional support negatively affects the quality of healthcare delivery, which impacts negatively on patient outcomes [51]. Hence, health policies are supposed to guarantee supportive work environments strengthened through institutional support systems, interdisciplinary collaboration, and open communication platforms.

5 Implications and recommendations

The results of this study have significant ramifications for Ghanaian mental health policy and service provision. It will take systemic adjustments, such as more financing for mental health services, better infrastructure, and the introduction of MHP-specific support programmes, to address the psychological suffering that MHPs endure. Additionally crucial are initiatives to raise mental health awareness and lessen stigma in society at large and within the healthcare system. Providing MHPs with chances for professional development, peer support, and frequent supervision may assist in improving their general well-being and lessen the effects of work-related stress.

6 Conclusion

The study revealed significant levels of psychological distress among MHPs in Ghana, with key contributing factors including workload, resource constraints, and lack of institutional support. Addressing these issues through systemic changes, such as increased funding and support programs, incorporating advancements in infrastructure, support networks, resources, and mental health literacy is crucial for improving the well-being of MHPs and the quality of mental

health care in Ghana. The quality and efficiency of mental health care delivery in Ghana can be significantly improved by making investments in the well-being of MHPs.

7 Limitations and implications for future research

The study's shortcomings include the cross-sectional design, which makes it more difficult to demonstrate causality, and the use of self-reported measures of psychological distress, which may be influenced by reporting bias. Particularly for those working in institutional settings, the results might not apply to all mental health professionals (MHPs) in Ghana. Prospective investigations ought to delve into the enduring consequences of psychological distress and its correlation with sociodemographic variables in the future. While intervention programmes intended to reduce MHP suffering should be evaluated for efficacy, further qualitative research might look into coping mechanisms and institutional support. It would also be beneficial to conduct larger research on the structural and systemic elements influencing the provision of mental health services. Nonetheless, another limitation of this study is that a specific number of participants were not selected from healthcare settings and regions, since a convenience sampling methodology was adopted, which could affect the generalizability of findings. For future research, we suggest the use of stratified or cluster sampling for a more ordered representation of settings across regions.

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Data availability The dataset(s) supporting the conclusions of this article is(are) included within the article.

Declarations

Competing interest The authors have no relevant financial or non-financial interests to disclose.

Ethics approval This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee for Humanities at the University of Ghana (Date: April 26, 2023/No: ECH 154/22-23).

Consent to participate Informed consent was obtained from all individual participants included in the study.

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