UNIVERSITY OF CAPE COAST

SOCIAL SUPPORT FOR THE MENTALLY CHALLENGED PATIENTS IN THE PSYCHIATRIC HOSPITALS OF GHANA

BY

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this University or elsewhere.

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Supervisors' Declaration

We hereby declare that the preparation and presentation of this thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

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ABSTRACT

Mental health remains largely ignored in many developing countries, including Ghana. Mental illness could be treated effectively through medication and psychotherapy. The study explored the availability of social support for the mentally challenged patients at the three psychiatric hospitals using both quantitative and qualitative methods in Ghana. Four hundred and nine in-patients (409) whose conditions had improved (lucid interval) participated in the survey. Twenty-three outpatients, 10 caregivers and 10 facility personnel were purposively selected for in-depth interviews. The results show that some of the patients received emotional, instrumental and informational support. Patients with less than 6 months' stay were more likely to receive support from the family and significant others than patients with more than 4 years stay at the hospital. Female patients were more likely to receive positive support whiles male patients were likely to receive negative support from parents and significant others. Inadequate funding of the psychiatric hospitals in the country had affected procurement of drugs and basic equipment for care. Lack of security to protect both patients and staff at the ward is a challenge. Public education by GHS/MOH of benevolent organisations in sustaining the provision of supports such as food, money and interaction with the mentally challenged is crucial. Ministry of Finance should release funding for the hospitals in order to pay debtors as well as get medications and necessary logistics for care. Ghana Health Service/MOH should recommend to Ghana Police Service for security to protect both patients and the staff at the psychiatric hospitals. District Assembly Common Fund's 2 percent to disables could also target mentally challenge at the psychiatric hospitals in Ghana.

KEY WORDS

Coping

Negative social support

Perceived social support

Psychotherapy

Social capital

Structural social support

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DEDICATION

To my wife, Margaret Akosua Korletey and my mother, Margret Eyram Dzitrie.

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CES-D	Chinese Centre for Epidemiological Studies-Depression Scale
CRPD	United Nations Convention on the Rights of Persons with Disabilities
DALYs	Disability Adjusted Life Years
GHS	Ghana Health Service
GNSPS	National Social Protection Strategy
GSS	Ghana Statistical Service
HDR	Human Development Report
HIV	Human Immunodeficiency Virus
ICESCR	Committee on Economic, Social and Cultural Rights
ICS	International Council for Science
ILO	International Labour Organisation
ISSC	International Social Science Council
LRC	The Law Reform Commission
MDGs	Millennium Development Goals
MHA	Mental Health Authority
MMDA	Metropolitan, Municipal District Assemblies
ODA	Official Development Assistance
OHCHR	Office of the UN High Commissioner for Human Rights
SDGs	Sustainable Development Goals
UNC	United Nations Charter

UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WFMH	World Federation of Mental Health
WHO	World Health Organisation
WHR	World Happiness Report
YLDs	Years Lived with Disability

CHAPTER ONE

INTRODUCTION

Background to the Study

The World Health Organisation's constitution emphasises that there cannot be health without mental health because of its contribution to the burden of diseases and mortality (WHO, 1946). Mental health is not receiving much attention like other physical diseases for several decades in many developing countries (WHO, 2008). Again, they neglect basic primary healthcare needs. The World Health Organization (World Bank & WHO, 2016; WHO, 2014) lists several risk factors that contribute to the development of long-term psychiatric conditions. These are; combination of biological (neurochemical imbalance), and psychosocial factors (work, stress and unemployment) which lead individuals to lives rife with inequality and inefficiency (WHO, 2008).

On determinants of Mental Health, Helliwell, Layard and Sachs (2015) posited that Mental Health is a key cause of adult life satisfaction. Half of mentally ill adults already showed symptoms at the age of 15 years. About 200 million children surveyed of diagnosable mental health problems and this condition requires treatment. The economic consequences of these health losses and treatment gap are very large as a study by the World Bank and WHO estimate that the cumulative global impact of mental disorders in terms of lost economic output amounts to US$ 16.3 million between 2011 and 2030 (WHO, 2013). According to the World Bank and WHO, (2016) every dollar ($1) spent on scaling up treatment for those with common mental disorders brings about four ($4) dollars in improved health and ability to work.

Psychiatric and neurological conditions could increase the total global burden by half, from 10.5 to 15 percent by 2020 (Murray & Lopez, 1996). Mental disorders make a substantial independent contribution to the burden of diseases (14 percent) worldwide (Prince, Patel, Saxena, Maj, Maselko, Phillips & Rahman, 2007) and in Ghana; it is about 9 percent (Muray & Lopez, 1996). It also affects 10 percent of the Ghanaian population (Ghana Statistical Service, 2012) and it is an important cause of long-term disability and dependency (Murray & Lopez, 1996). The estimation for low and middle-income countries are that between 76 and 99 percent of people with serious mental disorders do not have access to the treatment needed for their mental health problems (United Nations, 2015).

In some studies, disability, like mental health is significant in contributing to mortality. For instance, WHO estimates of neuropsychiatric disorders account for 1.2 million deaths every year. Once more, persons with major depression and schizophrenia have a 40 to 60 percent greater chance of dying prematurely than the general population (WHO, 2013). The older adults estimated to double from 12 to 22 percent, which is expected to increase from 900 million to 2 billion (WHO, 2015). People over age 60 face special physical and mental health challenges that need to be recognised (WHO, 2017). World Health Organisation (2017) posits that over 20 percent of adults aged 60 and over suffer from mental or neurological disorder and 6.6 percent of all disability (disability adjusted life years-DALYs) among over 60 is attributed to neurological and mental disorders and this in elderly accounts for 17.4 percent of years lived with disability (YLDs).

This condition has assumed an alarming proportion, which has attracted international bodies all over the world. This has led to declaration that there cannot be health without mental health (International Council for Science & International Social Science Council, 2015; WHO, 2005; WHO, 2013). The inclusion of mental health in the Sustainable Development Goal in order to attain a complete health is laudable. The World Health Organisation's definition of health is a state of complete, physical, mental and social well-being and not merely the absence of diseases or infirmity (WHO, 2012). This inclusion will help in the realisation of goal three targets 3.4, 3.5 and 3.8 of the Sustainable Development Goals. For a very long time, the mental and social well-being aspect of the concept of health is neglected in almost every part of the world and in particular Ghana and other developing countries (Agyapong & Mantey, 2011; Basic Needs, 2014: Fournier, 2011).

The attention given to mental health patients in Ghana with varying degrees of discrimination (Tawiah, Adongo & Aikings, 2015) violates the regulation stipulated in the United Nations Universal Declaration of Human Right Article 25 (United Nations, 1948). This states that, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing and medical care and necessary social services, and the right to security in event of unemployment, sickness, disability widowhood, old age or other lack of livelihood in circumstances beyond his control". According to Eaton, Kakuma, Wright, and Minas (2014), the crosscutting nature of mental health justifies its inclusion in the framework for action. This will increase the likelihood of achieving global priorities for development such as poverty reduction, economic development, improved health and ensuring the most vulnerable are not left out (Eaton et al., 2014; Helliwell, Layard & Sachs, 2013; World Federation for Mental Health, 2015; WHO, 2014).

Mental health has received a global attention in the Agenda 2030 of the Sustainable Development Goals (SDGs) and this has led to many countries to commit many resources to provide good mental health care. (World Bank & WHO, 2016; WHO, 2015). However, in Ghana, as at 2014 Government funds allotted to mental health care, Teaching Hospitals and subvented organisation is 4.5 percent of the entire total health budget (Ministry of Health , 2014). Currently, there is Mental Health Act 846 (2012) in place, but its implementation is facing serious resource constraints (Walker, 2015). Walker (2015) in his study on 'Challenges and Priorities for Implementation of the Act' found that there are challenges to the full implementation of the Act especially financial resources, which will delay its intended purpose.

The importance of social support is enshrine in the literature (WHO, 2013). Care and respect especially in Ghanaian societies received through social ties and a sense of satisfaction and wellbeing can buffer against health problems (Cohen & Wills, 1985). Most studies find that the health effects of social support/social relationships may be as important as effects of established risks factors such as smoking, obesity and high blood pressure (McDowell & Serovich, 2007).

The World Health Organisation (2003a) on social determinants of health, posits that social support for instance provides psychological adjustment, improved efficacy, resistance to diseases, recovery from diseases, reduce mortality and better coping with upsetting events (WHO, 2003a). Mentally ill persons are among the most vulnerable people in society. They are often subject to discrimination, social isolation and exclusion, human rights violations and demeaning treatment (World Federation for Mental Health, 2015). This leads to neglect of their social support and self-approach (Fournier, 2011).

Conversely certain aspects of social support can in itself be detrimental, which needs to be explored (Cohen, Gottlieb, & Underwood, 2000; Uchino, 2004). This can lead to negative consequences theorised by Cohen (2004) as negative relationship as one of the areas of social support. Obligatory social ties can produce stressful demands that could outweigh the positive consequences for self-esteem, competence or identity (Thoits, 1995). According to Uchino (2004), social ties can also reinforce social pressures to engage in negative health behaviours, for instance, alcoholism which in itself can lead to depression and others.

Problem Statement

Proper mental health care has gained much attention from international bodies such as International Council for Science and International Social Science Council. They have concluded that proper mental health care delivery should be an integral part of the process of maintaining general health for all (ICS & ISSC 2015; WHO, 2015). The inclusion of mental health in Sustainable Development Goal (SDGs) is laudable. For example, the World Health Organisation's definition of health state that it is a complete, physical, mental and social well-being and not merely the absence of diseases or infirmity (WHO, 2012). This inclusion of mental health in the Sustainable Development Goals helps the realisation of goal three targets 3.4, 3.5 and 3.8 of the Sustainable Development Goals. For a very long time, the mental and social well-being aspect of the concept of health not given attention in many parts of the world including Ghana (Agyapong & Mantey, 2011; Basic Needs, 2014; Fournier, 2011).

Mental disorders make a substantial independent contribution to the burden of diseases (14 percent) worldwide (Prince et al., 2007; Murray & Lopez, 2006). In Ghana, it is about 9 percent (Muray & Lopez, 1996) and 15 percent burden among adults aged 15-59. Mental disorders are as one of the major causes of long-term disability and dependency (Murray & Lopez, 1996). In low and middle-income countries such as Ghana and Mali, it estimated that the percentage of people with serious mental disorders who do not have access to the treatment needed for their mental health problems is between 76 and 99 (WHO, 2008).

In some other studies conducted by WHO (2008), disability, as in the case of mental health is significant in contributing to mortality. For instance, WHO reported that neuropsychiatric disorders cause 1.2 million deaths every year. Of this number, 1.4 percent of all years-of life-lost and about 800,000 people commit suicide and of this figure, 86 percent are in low-income and middle-income countries and more than half are between ages 15 and 44 years (Prince et al., 2007). Again, persons with major depression and schizophrenia have a 40 to 60 percent greater chance of dying prematurely than the general population (WHO, 2013).

WHO (2015), realised that although mental health has now been given a global attention, most countries face challenges in committing resources to solve the problems. For instance, according to Ministry of Health (MOH), (2014) in

Ghana, the Government spends only 4.5 percent on mental health and other subvented organisation of the entire total health budget. Currently, there is Mental Health Act in place Act 846, 2012, but full implementation is facing some serious resource constraints. As a result, most mental health problems go unnoticed. It has estimate that 2.4 million Ghanaians have mental health disorder of some sort. However, only 67,780 have been treated which leave treatment gap of 97 percent (Roberts, Asare, Mogan, Adjase & Osei, 2013).

Again, no mental health services had access to programmes outside the mental health facility that provided outside employment for patients with severe mental disorders. These fall short of WHO's Mental Health Action Plan 2013 to 2020 which recognises the vital role of social support and care for the mental health patients. In addition, there was no insurance scheme for physical health care and so most mentally challenged have their physical health not treated. Moreover, there were no services exclusively for children and adolescents although 14 percent of all those treated were children (Roberts et al., 2013).

Cutrona and Rusell (1990) posited that social support for instance, provides psychological adjustment, improved efficacy, resistance to diseases, and recovery from diseases and reduced mortality and better coping with upsetting events (Cutrona & Rusell, 1990). Mentally ill people are among the most vulnerable people in society. They are often subject to discrimination, social isolation and exclusion, human rights violations and demeaning stigma (World Federation for Mental Health, 2015). This leads to neglect of their social support and self-approach (Fournier, 2011). A study by Omalayo, Mokuolu, Balogun, Omole and Olawa (2013) lent credence to the argument that mental illness could be controlled or treated effectively through medication and/or psychotherapy, which involve various levels of social support. Untreated mental illness can disrupt an individual's personal, social, educational and work activities and in some cases, may lead to suicide.

Even though social support is good for health, (Thoits, 2010; World Health Organisation, 2013; Uchino, 2004) said very few professionals refer their clients to mutual support groups and few individuals with serious mental illnesses make use of these options on their own (Salzer, McFadden & Rappaport, 1994). Again, in Ghana, most studies on mental health were purely clinical. There have also not been any comprehensive surveys as well on prevalence of mental disorders in Ghana (Roberts, et al., 2013). Few studies however are in the domain of social support and mental health issues. For instance, a study by Sackey and Sanda (2011), on 'Social Support as a Mental Health Improver for Managerial Women in Organisational Work Environment' found that spousal support provided women with a sense of security and stability at home and also reduced their possibility of being confronted with role conflict.

Likewise, Atefoe, Akotia, Kugbey, Atindanbila (2014) looked at the effect of social support, religion and social negativity on women's mental health in Accra. They found that religiosity had a positive psychological well-being on overall health index and a significant negative relationship with psychological distress, perceived social support and social negativity had a significant relationship with a mental health outcome (Atefoe et al., 2014). Agbolosoo, (2014), conducted a study on existing social support services and the well-being of children with disabilities in Kadjebi District and found that children with disabilities were not discriminate against in the Health and Educational institutions because they have equal access to social intervention programmes in the study area but rather suffer discrimination within the family system.

In addition, not all aspects of the social support and socio-demographic variables was explore in Ghana on mental health to reflect its multidimensional nature as tabled by Lourel, Hartmann, Closon, Mouda & Petric-Tatu, (2013). For instance, structural, functional and negative interactions or social negativity reflects the multidimensionality (Lourel, et al., 2013) of social support this study seeks to explore. Furthermore, the functional aspects include that actual support and perceived support which most studies have not explored in Ghana. Current debate that women receive more support (Atefoa et al., 2014; Simon, Chen & Dong 2014; McDowell & Serovich, 2007) than men is examine in the study.

Mental health is a constitutional mandate for all countries however; it has not received much attention like other physical diseases in Ghana. There are factors that contribute to mental health; these are a combination of biological and psychosocial factors. Treatment gap in Ghana is about 98 percent. These gaps have made the UN to include the mental health in the goal 3 targets 3.4, 3.5, and 3.8. The attention given to mental health in Ghana violates the regulations stipulated in the UDHR. Because of discrimination against mental health patients, the Law, Act 846 was pass in 2012 to guide operation of mental health in Ghana.

However, the Act is bedevilled with challenges; key among them is financial, which need a solution. Social support therefore is a tool that is deploy in addition to medical to manage the problem among mentally challenged. This is because social support for instance, provides better copping for individuals, who needs it nonetheless, very few professional made use of it. Again, very few studies have examined social support and mental health in Ghana therefore, this study brings out social support and its multidimensional nature where functional, structural and negative supports are explore.

Objectives of the Study

The main aim of this study was to explore availability of social support for the mentally challenged patients at three psychiatric hospitals in Ghana. Specifically, the study sought to:

1. Identify the types and sources of social support for mentally challenged in the three psychiatric hospitals of Ghana;
2. Assess effects of social support among the mentally challenged in the three psychiatric hospitals of Ghana;
3. Explore the factors that constrained caregivers in caring and providing social support for the mentally challenged in the three psychiatric hospitals of Ghana.

Research Questions

1. What types of social support do patients need and where do they get it from as they receive care in the hospitals?
2. Do negative and positive aspect of social support have unique effects on health?
3. What are the experiences that constrained informal and formal caregivers or the burden of caregiving on their physical and mental health?

Hypothesis of the Study

The following hypothesis was tested during the study:

1. H0: There is no significant relationship between sociodemographic variables (age, education, household size, church attendance and parents living or dead) and support from the family for the mentally challenged.

Rationale of the Study

According to World Health Organisation (2013), to be able to achieve a holistic health, mental health cannot be ignored and also an integrated approach including social support is very important (WHO, 2013; Mental Health Act, 2012). Basic Needs (2014), has integrated both medical treatment and psychosocial approach, which involves various forms of social support to mental health problems in Ghana. This includes self-help groups, which reduce stigma among the mentally challenged. The importance of social support in mental health has made most notable organisations (WHO, 2013) propose the inclusion of mental health in primary care delivery which includes a multi-sectorial approach involving communities in primary health care delivery of mental patients.

In demonstrating the importance of social support and how relevant it is in Africa and particularly Ghana, Gyekye (1996), posits as expressed in maxims such as —it is the human being that is needed and —it is the human being that counts; I call upon gold, it answers not; I call upon cloth, it answers not; it is the human being that counts. Individuals are socialised to think about themselves in relation to their relatives (both nuclear and extended family members) and take the responsibility of the well-being and harmony of the family (Belgrave, & Allison, 2010). In this sense, each member of the family expects to provide and receive some form of assistant and support, which demonstrates the importance of social relations in the African society.

There is one Psychiatrist per 1.5 million people in the whole country and major Psychiatric hospitals are under financed, congested and under-staffed (Fournier, 2011). Further, most mentally challenged can be seen on streets of Ghana and some are abandoned by family members at the hospital which poses health risk to the citizens of the country (Agyapong & Mantey, 2011; Fournier, 2011). Social support therefore has become crucial and additional care that mentally ill in Ghana could receive for coping with the risk (Basic Needs, 2014; Lourel, et al., 2013; Helliwell, Layard & Sachs, 2014).

This study, apart from adding to existing literature tests the hypothesis in understanding the relationship between social support and socio-demographic variables on the mentally challenged. Again, various policies could be influenced, especially in the domain of social support and primary health care in mental health being promoted by World Health Organisations and other agencies. Social support work in the field of mental health is little; this study therefore could generate findings, which could motivate other researchers and students to do more studies in this field.

Organisation of the Study

The study is organised into nine chapters. Chapter One gives a background and justifies the reasons for the study. Chapter Two dwells on mental health system in Ghana and legal framework on mental health from the world perspectives and Ghana in particular. Chapter Three looks at related reviews on empirical studies on social support. It also looks at concept of health, mental disorders and social support.

Additionally, it looks at issues in enabling environment that provides social support for the mentally ill. Chapter Four looks at theoretical frameworks and models on social support. Chapter Five is on the methodology, proposing two main schools of thoughts that guides the study. Data and research design discussed in this chapter. Chapter Six presents the results and discussions on types of social support and their sources for the mentally challenged in the various facilities. In addition, it tests the hypothesis of significance relationship between age, gender, educational level and a patient's level of support as well as types of support available to them. Chapter Seven presents results on assessment of social support to evaluate between negative and positive social support. Chapter Eight presents results on challenges, constraint that both formal and informal caregivers face in providing support and care for patients.

Finally, Chapter Nine concludes the study by providing summary, main findings, conclusion and policy implications as well as recommendations. The study provide research limitation and suggestions for future studies in mental health work is proffered.

CHAPTER TWO

LEGAL FRAMEWORK AND POLICIES ON MENTAL HEALTH

Introduction

This chapter looks at policies and legal frameworks on mental health from the world perspectives and Ghana in particular. Furthermore, the chapter recounts policies, describes the legal frameworks and agents with mental health, and discusses the roles of the major agents of mental health delivery in Ghana.

The United Nations Universal Declarations of Human Rights

United Nations Universal Declarations of Human Rights of which Ghana is part was declare on December 10 1948. This historic Act has mandated all member countries by the Assemblies to publicise the text of the declaration in all institutions and other public places. In the framework, the United Nations Charter (UNC) has reaffirmed its faith in fundamental human rights in the dignity and worth of human person and unequal rights of men and women and have determined to promote social progress and better standards of freedom in larger freedom (United Nations, 1948). Follesdal (2009) stated that human rights are claims that certain freedoms are very important and that all persons have the moral obligation of protecting and respecting these freedoms for everybody.

Article 25 (1) of the UNC indicates that, "Everyone has the right to a standard of living adequate for the health and well-being of himself/herself and of his/her family. This including food, clothing, housing and medical care and necessary social service and the rights to security in the event of unemployment, sickness, disability widowhood, old age or other lack of livelihood in circumstances be young his/her control." In spite of this, the situation in Ghana is different as mentally challenged and other disabled persons are abuse, discriminated against thereby violating their Human Rights as well as the provision in Ghana's Constitution. (Agyapong & Mantey, 2011). Article 29 (4) which states that disabled persons shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature (Constitution of Ghana, 1992). According to Fournier (2011), mentally challenged in Ghana, are some of the most vulnerable people in society. They are subject to discrimination, social isolation and exclusion, human rights violations, and an ancient, demeaning stigma, which leads to bereavement of social support, self-reproach, or the decaying or straining of important relationships. Furthermore, Tawiah, Adongo and Aikings (2015), found that there has been an increased public health attention given to mental health because of the enormous negative impact, stigma and discrimination.

Once more, World Federation for Mental Health (2015) asserted that all over the world, people with mental disorders and their families find dignity absent in their dealings with health care providers and with society. Meanwhile, Article 1 of the Universal Declaration of Human Rights states that, all human beings are born free and equal in dignity and rights. They are endow with reason and conscience and should act towards one another in a spirit of goodwill. However, the mentally ill feel demeaned by the manner in which they are treated. Once more, health care professionals do not have the time needed to address difficult problems. The mentally challenged do not get the coordinated care for other illnesses that may be present resulting in neglect of their overall health and this ultimately shorten their life span (WFMH, 2015).

According to the United Nations (2015), people with this condition have their life expectancy reduced by about 20 years. These actions against the mentally challenged, especially in Ghana violates all the provisions on disability and vulnerability in the Conventions as well as the (Constitution of Ghana, 1992)

International Convention on Economic, Social and Cultural Rights (ICESCR)

The International Convention on Economic, Social and Cultural Rights adopted in 1966 Article 12, states that, State Parties to the present covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Covenant proffered some steps to take by state parties. These are provision for the reduction of stillbirth rates and for the healthy development of the child, the improvement of all aspects of environment and industrial hygiene, as well as prevention, treatment and control, of epidemic, endemic, occupational and other diseases. Besides, it highlights the creation of conditions, which will assure all medical service and medication. This aspect of the covenant mandates parties to treat the root determinant factors of mental health. This is because risk exposures in the formative stages of life can affect mental well-being or predispose towards mental disorder many years or even decades later (WHO, 2014). Mental health and many common mental disorders are shape largely by the social, economic, and physical environment in which people live (WHO, 2014).

The Committee which monitors the ICESCR adopted general comments on the right to health at its 22nd session in 2000 (General Comment 14) in a bid to provide guidance to countries on the meaning and requirements of implementing this right; In recognition that, many people experience barriers to health and mental health services and care. The committee stated that health care services require adequate funding to ensure that health facilities, goods services and programmes as well as health care professionals and essential eradications are available in sufficient quantity.

Nonetheless, an assessment of mental health policy in Ghana, South Africa, Uganda and Zambia by Faydi, Funk, Kleintjes, Ofori-Atta, Ssbunnya, Mwanza, Kim and Flisher (2011) discussed the six gaps that could impact on the policies' effect on countries' mental health systems. They are; lack of internal consistency of structure and content of policies; superficiality of key international concepts, lack of evidence on which to base policy directions. The rest are inadequate political support, poor integration of mental health policies within the overall national policy and legislative framework. Again, lack of financial specificity (Faydi, et al., 2011).This assessment echoed the statement of WHO (2003b) that enjoying mental health rights would work when the International Human Rights discourse recognised that certain socio-political and economic conditions need to exist in order to promote the mental well-being of the population (WHO, 2003b). From the discussion, governments as well as state organisations are as key actors in providing for mental health.

World Health Organisation's Constitution

The World Health Organisation's Constitution, one of the International Bill of Rights, which falls in line with the Charter of the United Nations, found that the principles that established the Constitution are basic to happiness, harmonious relations, and security of all people. It stated further that Health is a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity (WHO, 1948). It also observed that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination on race, religion, and political belief, economic or social conditions. Moreover, the health of all people is fundamental to the attainment of peace and security. Moreover, it is dependent upon the fullest cooperation of individuals and states (WHO, 1946). Unstable political and economic regimes especially in Africa has affected health delivery to the detriment of mental health. According to Helliwell, Layard and Sachs, (2013), mental health has been a major cause of misery and unhappiness in the world (Helliwell, Layard & Sachs, 2013).This provision by WHO made it mandatory for State Parties to take serious steps towards addressing the needs for mentally challenged since 1948; however, this provision is violated for a long time.

Unfortunately, even though mental health forms key part of WHO constitution, for a long time it has neglected it in the development discourse. According to the Director General of WHO, even though mental well-being is a fundamental component of WHO's definition of health where good mental health enables people to realize their potential, cope with the normal stresses of life, work productively, and contribute to their communities, the world has a long way to achieve it (WHO, 2013). Unfortunately, trends such as, neglect of mental health services, care and abuses of human rights and discrimination against people with disorders and psychosocial disability has seriously affected delivery. The World Federation for Mental Health (2015) has echoed similar theme. Indeed, the Declaration of Human Rights and Mental Health Article 1, states that mental health promotion is a responsibility of governmental and non-governmental authorities as well as the inter-governmental system, especially in times of crisis. This article linked with the WHO's definition of Health and further illustrated that health and mental programmes shall contribute both to the development of individuals and families' responsibility for personal and group health as well as promoting the highest of possible quality of life.

African Charter on Human and People's Right

The African Charter on Human and People's Right (1982) reaffirmed regulation on health and peoples right. It submits in Article 16 (1) that, every individual shall have the right to enjoy the best attainable state of physical and mental health. Article 2 similarly states that, parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick. According to Mfoafo-M'Carthy and Huls (2014), there were certain cultures that perceived mental illness as a sign of weakness and these results in family members or caregivers distancing themselves from the mentally challenged since these groups were vulnerable and therefore were unable to contribute any resources to the family. They were beaten and maltreated because there is no regard for them. In this regard, even though, these conventions are there to protect the disabled, cultural issues also contribute significantly towards making progress in protecting these groups of which the mentally challenged are greatly affected (Mfoafo-M'Carthy & Huls, 2014).

Similarly, in many African countries, although most of the conventions mention governments to be directly in charge of mental health, inadequate resources made it difficult for mental health conditions to be improved and as a result worsen their plight (Mfoafo-M'Carthy & Huls, 2014). World Health Organisation (2015) asserted that while the political will to invest in mental health continues to grow, it is still inadequate. For instance, public spending on mental health continues to be very low at 2 percent or less of total health-care spending in most low and middle-income countries or less than 2 percent per capita (WHO, 2015). Ghana as a case in point, spends only 4.5 percent of total health budget on mental health and subvented organisation as at 2014 (MOH, 2014) which is inadequate to provide for essential drugs, food and other psychosocial care.

United Nations Convention on the Rights of Persons with Disabilities (CRPD)

The Conventions on the Rights of Persons with Disabilities directs as in the case of Human Rights on General Obligation in Article 4, that State Parties are to ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on basis of disability. Key areas to address are adoption of appropriate legislative measures to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities. Article 5 (1) of the Convention discusses equality and non-discrimination. It states that States Parties recognise that all persons are equal before and under the law and are entitled without any discrimination to equal protection against discrimination on all grounds. It directs steps to ensure that reasonable accommodation provided. Article 6 also touches on women and girls' disabilities, which are subject to multiple discriminations, and in this regard, States Parties shall take measures to ensure the full and equal enjoyment of all human rights and fundamental freedoms. Article 7 centres on children with disabilities. That States Parties in their duty should take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children. Word Health Organisation (2015), discussed in their study on Promoting Rights and Community living for Children with Psychosocial Disabilities that some children are born with disabilities, and others develop disabilities in their early years.

These children need security, care and love, best provided by keeping them with their parents or caregivers in their own community (WHO, 2015). According to the findings of the study, institutions find it difficult to provide the individual care that children with psychosocial disabilities need, and become places where children are subject to demeaning treatment and forgotten by society, excluded from education, work and normal social activities (WHO, 2015). Since parents are primary caregivers, evidence from the study posits that for children with psychosocial disabilities, community services lead to better developmental, health and human rights outcomes than institutional care (WHO, 2015).

According to World Report on Disability (2015), Disability is part of the human condition. It stated that everyone will be temporarily or permanently impaired at some point in life and those who survive to old age will experience increasing difficulties in functioning. Most families especially extended have disabled and many non-disabled people take responsibility for supporting and caring for their relatives and friends with disabilities (Mishra & Gupta, 2006). World Health Organisation (2015) posited that while most have good mental health, many older adults are at risk of developing mental disorders, neurological disorders or substance abuse problems as well as other health conditions such as diabetes, hearing loss, and osteoarthritis. Furthermore, as people age, they are more likely to experience multiple conditions at the same time. The report described disability as a human right issue. Quinn and Degener, (2002) argued that people with disabilities experience inequalities for instance, when they are denied equal access to health care, employment, education or political participation because of their condition. They stressed that people with disabilities are subject of violation of dignity, issues of violence abuse, prejudice or disrespect.

Human Development Report (HDR) (2014) presented part of Ban Ki-moon's (Former UN Secretary General) address to the United Nations General Assembly that the world has to pay particular attention to the needs and rights of the most vulnerable and the excluded in the world. He called for a new vision that can bring change and aspiration to ensure 'a life of dignity for all'. This statement has strong linkage with the theme for the celebration of the world mental health day in October 2015, which has its theme of 'Dignity in Mental Health'. Dignity is observed to be absent in treatment of mental health which has led to the neglect and abuse of mental health patients' globally. According to Human Development Report (2014), eliminating extreme poverty is achieve with focus on vulnerability and human development. The issue of sustained public support that strengthens social and economic resilience for the poor and the vulnerable of which the mentally challenged are part of could reduce systemic sources of vulnerability for the poor (HDR, 2014).

World Health Organisation Quality Rights Tool Kit developed in 2012 for assessment and improving quality of human rights of mental and social care facilities summarised five key themes drawn from Convention on the Rights of Persons with Disabilities (WHO, 2012). The first theme drawn from article 28 requires that people with disabilities be provided with an adequate standard of living including adequate food, clothing, shelter, clean water devices and other assistance for disabilities and continuous improvement of their living conditions. Conditions for the mentally challenged assessed in many countries are overcrowding, poor hygiene, poor sanitation and others. WHO (2012), and others find that people lack proper clothing, clean water, food, shelter and other human resources which is at variance with the provisions in CRPD. World Report on Disability (2015) found in relation to the provisions in the article 28 of CRPD that people with disabilities and their families were more likely to experience economic and social disadvantage than those without disabilities since disability leads to vulnerability (World Report on Desability, 2015).

The second theme of WHO Quality Rights Tool Kit is on the right to enjoyment of the utmost attainable standard of physical and mental health (Article 25 of the CRPD). Access to basic mental health care and treatment is lacking in many countries. Services are also very far from homes of the mentally challenged. According to WHO (2015), "The right to the highest attainable standard of health" requires a set of social criteria that is conducive to the health of all people, including the availability of health services, safe working conditions, adequate housing and nutritious foods. Achieving the right to health relate to that of other human rights, including the right to food, housing, work, education, non-discrimination, access to information, and participation.

However, ineffective or harmful treatments are applied and co-morbid general health problems are ignored (WHO, 2012; Fournier, 2011). It also found that institutional services are emphasised to the detriment of outpatient's community based facilities and the focus of many services is on detaining people rather than helping them to develop their abilities in order to recover and reintegrate into the community (WHO, 2012). Article 25 of the CRPD hence requires that people with disabilities be given the health services they need as close as possible to their communities. It also requires that they give the same range of quality and standard of free or affordable health care, including sexual and reproductive health as well as other people. Basic Needs (2014), an NGO in Ghana use of a model which involves a meaningful work and community support as well as treatment to help improves lives of the mentally challenged has proven promising in supporting the mentally challenged. In addition, WHO (2008) opined that community based services place greater emphasis on autonomy and provide needed care based on people experience and culture (WHO, 2008).

The right to exercise legal capacity and the right to personal liberty and the security of persons with disabilities is use for assessment (Article 12 and 14 of CRPD). The assessment tool found that mentally challenged on regular basis do experience violations of their rights to exercise their legal capacity. They are incapable of making decisions about their own lives, and key choices that concern them. For instance, the mentally challenged do not have a say about their treatment, medical treatments and others. A study by Diseth and Hoglend (2011) found that individuals with mental illnesses who are receiving care in psychiatric institutions suffer greater human rights violations than individuals who are in conventional facilities. They note that while those in psychiatric care may not have committed a crime, they are subjected to a similar removal of rights and liberties as with criminal offenders solely because mentally challenged are perceived to be dangerous and less competent (Diseth & Hoglend, 2011).

Similarly, Article 12 of the Convention on the Rights of Persons with Disabilities (CRPD) states that people have the right to be recognised everywhere as persons before the law. It also re-asserts the rights of people with disability to exercise their legal capacity on an equal basis with others in all aspects of life. They must therefore remain central to all decisions that affect them, including their treatment, where they live and their personal and financial matters. Article 12 further states that, when needed, people supported in exercising their legal capacity. This means that they should have access to a trusted person or group of people, who can explain issues related to their rights, treatment and other relevant matters and who can help them to interpret and communicate their choices and preferences. Again, Article 14 of the CRPD focuses on the right to liberty and security of persons. It states that people with disabilities must not be deprive of their liberty unlawfully or arbitrarily, that any deprivation of liberty must be in conformity with the law and that the existence of a disability shall in no case justify deprivation of liberty.

In Ghana, although the Constitution of Ghana (1992) states that every person shall be entitled to his or her personal liberty, which is right for all. However, inadequate human resources in terms of psychiatrics doctors and nurses have compelled many families to send their mentally challenged to religious homes where their rights are deprive, by chaining and confining most of the mentally challenged in an enclosure. Such treatment is ancient, demeaning which leads to bereavement of social support, self-reproach, or the decaying or straining of important relationships (WHO, 2002). There are only three psychiatric hospitals in the country all of which are in the South of the Coastal belt of the country with few options for care outside these facilities. Since there are widespread beliefs that mental illness and epilepsy have spiritual causes, many people resort to traditional healers whose treatment methods could sometimes be inhumane (Basic Needs, 2014; Fournier, 2011).

Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse is the fourth theme reviewed by the WHO quality right tool kit (Articles 15 and 16 of the CRPD). It finds that people in inpatient facilities and social care homes are expose to physical, sexual and mental abuse. Most people spend more days, years of living aimlessly, in boredom and total exclusion in seclusion in cells and most of them restrain using chains. Mentally challenged have also been found to be often over medicated in order to make them docile and easy to manage. International human rights laws have seen this as ill-treatment and torture which eventually violates all provisions in the International Bill of Rights.

Article 15 of the CRPD requires that all appropriate measures taken to present people with disabilities from torture or cruel, inhumane or degrading treatment or punishment. It also states that no one should be subject to medical or scientific experimentation without his or her consent. In article 16 of the Convention, it requires that all measures taken to protect against and prevent all forms of exploitation, violence and abuse, including provision of protection services. Discrimination as posited by Gostin (2001) can affect negatively on mental health. The writer further stated that victims of discrimination were vulnerable to limitations in civil, political, economic, social, and cultural rights that make it difficult for them to integrate into society and lead well-balanced and productive lives. The report found that the negative repercussions of discrimination itself could deeply affect a person's dignity and self-esteem, which is detrimental to mental health.

Article 19 of the CRPD, which, deals with the right to live independently and be included in the community has also been, reviewed (WHO, 2012). It submits that people with disabilities have the right to live in community and that government must take effective appropriate measures to facilitate their full inclusion and participation in society. It further states that people might decide where and with whom they live; they must not obliged to live in particular arrangements. Article 19 further states that people must have access to a range of in-home, residential and other community support services, including the personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community. Other discussions closely linked to this convention for disabled on the rights to education, to work and employment and to participation in political, public and cultural life and in recreation, leisure and sport. It further states that people with disabilities have the right to live in community and that government must take effective appropriate measures to facilitate their full inclusion and participation in society. It additionally states that people's right to decide where and with whom they live and that, they must not be obliged to live in a particular arrangement.

World Health Organisation (2001) found that the link between poverty and increased risk of mental disorders have become increasingly apparent over the last decade. Issues such as unemployment, low levels of education and lack of food, clothing and shelter and access to health such as health insurance limits people's ability to be active and productive members of society to realise their potential and to be mentally as well as physically healthy. These factors act as barrier to health and mental health care services.

Structure of the Mental Health Framework in Ghana

Ghana has had quite a number of laws and policies to protect the mentally challenged in the country. These laws and policies however, have been bedevilled with implementation challenges and key among them is finance. This session presents a historical view of some of the laws both local and international policies that were design to protect the mentally challenged in Ghana.

Lunatic Asylum Law

Ghana's first law towards mental health was the Lunatic Asylum Ordinance of 1888 enacted by the Governor of Gold Coast, Sir Griffith Edwards. In this act, they mandate officials to arrest so-called insane people and place them in a special prison in Accra. When the prisons were fill they built Lunatic Asylum in 1906, which later transformed into Accra Psychiatric Hospital in accordance with International laws in 1951.The hospital then depicts prisons as it was made with high walls and barbed wires. This historical structure has affected immensely the way the mentally challenged are until date. There were innovations such as removal of chains from patients, abstaining from punishment of patients and the use of other forms to calm patients. This innovation, especially chaining and confinement persist in care homes and other hospitals in Ghana.

Mental Health Decree of 1972

Forster (1971) discovered that in the late 1960s, there were major reviews of mental health act leading to the enactment of the Mental Health Decree, NRCD 30, in 1972. Unfortunately, over the forty years of its existence, the implementation of the Mental Health Decree (NRCD 30) had not happened. Again, since the early 1990s, several unsuccessful attempts were made to enact a new mental health act. Before 2004, The Law Reform Commission (LRC) was involved in revisions of the 1972 Decree. It is surprising however that these earlier revisions including the Mental Health Act, 1990, (LRC,1990) were not enacted and even during periods of constitutional rule there was no law. Although the 1972 Mental Health Decree has provisions for involuntary admission, including the rights to appeal, it was not use. It also involved the accreditation of professionals and facilities as well as enforcement of judicial issues for people with mental illnesses and mechanisms to implement the provisions of mental health legislation.

According to Ofori-Atta, Read, Lund and MHaPP Research Programme Consortium (2010), the review of 1972 legislation using WHO checklist on mental health legislation identified several flaws. For instance, inadequate attention to human rights provisions for service users which includes the right to humane treatment; confidentiality and privacy; informed consent; the rights of carers and families of users; competency, capacity, and guardianship issues; involuntary admission; and issues of seclusion and restraint. Issues of seclusion and restraint for instance, contravened the provisions in the international human right framework in Article 25 of the CRPD which requires that people with disabilities be given the health services they need as close as possible to their communities.

In addition, the situational analysis discovered that there is little protection in the legislation of vulnerable groups, including minors and women.

There is no provision for financing of mental health care and inadequate promotion of mental health within primary or community-based care. There is also insufficient promotion of access to psychotropic drugs, and no provision for educational activities, vocational training, leisure activities and the religious and cultural needs of people with mental disorders. Yet again, there is no provision made for the involvement of users of mental health services, families and carers in mental health policy and legislation development and planning (Ofori-Atta, Read, Lund and MHaPP Research Programme Consortium 2010). Because of the aforementioned, a new legislation to be at par with the international bills of rights was inevitable hence, the new Mental Health Act.

Mental Health Act 846, 2012

A revised Mental Health passed in 2012, which is the Mental Health Act 846, 2012. The Mental Health Act adopts a human rights approach to mental health, in accordance with the UN Charter on Human Rights and international agreement on the health care needs of a person with mental disorder. The new Mental Health Act focuses on improving access to care for people with mental illness, epilepsy, including the poor and vulnerable, safeguarding human rights and promoting participation in restoration and recovery. The law provides for the integration and regulation of spiritual and traditional mental health practices in Ghana. It supports decentralisation of mental health care and places emphasis on community rather than institutional care. It addresses many of the challenges and weaknesses of the previous Decree, which provides for a mental health authority, a mental health review tribunal, and the protection of the rights of people with mental disorder, including the principle of the least restrictive environment and the right to information and participation (Robert et al., 2013; Mental Health Act, 2012).

Issues of non-discrimination have been spelled out in the Mental Health Act 846, 2012 in section 54 requires that a person with mental disorder is entitled to the fundamental human rights and freedoms as provided for in the constitution. A person with past or present mental disorder shall not be subjected to discrimination and, whatever the cause, nature or degree of the mental disorder, has the same fundamental rights as a fellow citizen. A tenant or employee who develops mental disorder shall not be evicted from the place of residence of that person, or dismissed from the place of employment of that person on the basis of mental disorder. Further, on basic human rights Section 55 of the Law states that, a person with mental disorder has the right to enjoy a decent life as normal and as full as possible which includes, the right to education, vocational training, leisure, recreational activities, full employment and participation in civil, economic, social, cultural and political activities and any specific limitations on these rights shall be in accordance with an assessment of capacity. There is emphasis on humane treatment and treating mental ill persons with dignity as illustrated by WFMH (2015).

There is provision for vulnerable groups such as women and children in the law, for instance, in section 64 of the Act. This requires female patients in a mental health facility to have separate sleeping accommodation from male patients. It also requires that females with mental disorders should have the same treatment as men with mental disorders in matters relating to civil, political, economic, social and cultural rights. Female patients should not be discriminated with respect to treatment, community care, voluntary and involuntary treatment.

There should be special provision for the accommodation of females whose conduct may at any time, be harmful to them or other patients.

The provision for children is in section 65 requires that a child receiving psychiatric treatment should as far as possible, be treated in a least restrictive environment. However, cases where they require admission, children be accommodated separately from adults, and their developmental needs shall be taken care of. Parents or guardians of children under the age of eighteen years receiving psychiatric treatment should represent them in matters concerning the mental wellbeing of the children including consent to treatment. Special provision made for the accommodation of children whose conduct may be harmful to them or other patients.

According to WHO (1996), psychosocial instead of psychiatric implied a shift from an illness model towards a social functioning model. United States Psychiatric Rehabilitation Association (2011) further explained that psychosocial model should be psychiatric rehabilitation services that are collaborative, person-directed, and individualized, an essential element of the human services spectrum, and should be evidence-based. It includes focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice. This is an example of Basic Needs model in Ghana that work in partnership with mentally ill and instead of working for them. For instance, meaningful work and community support in addition to treatment to help improve lives (Basic Needs, 2014).

Section 57 of mental health Act in Ghana provides for standard of treatment for the mentally challenged. It requires that, a person with mental disorder have the right to the highest attainable standard of mental health care. Moreover, this group of persons are entitled to the same standard of care as any person with physical health problems. Treat them on an equitable basis including quality of in-patient food, bedding, sanitation, buildings, levels and qualifications of staff, medical and related services and access to essential medicines. Again, person with mental disorder should not be subject to torture, cruelty, forced labour and any other inhuman treatment. Additionally, the Act provides for persons with mental disorders to have access to psychotropic drugs and any other psychosocial rehabilitative interventions at different levels of care as appropriate. It also requires that intrusive and irreversible treatment like electro-convulsive therapy and psychosurgery should not be used for emergency cases.

One of the critical concerns of Ghanaians is the nature in which the mentally challenged is allow to roam the street of cities in the country, which has been recognised by the Act and therefore provided directions in section 73. Police officers are to remove a person to a facility or mental health facility for assessment under a certificate of urgency if that person is found in a public place appearing to be suffering from mental disorder, is highly aggressive or showing out-of-control behaviour, and appears to require immediate care, control and treatment. Family members, caregivers, health professionals, social welfare officers and any other citizens may also seek the assistance of the police to take a person to a facility or mental health facility under a certificate of urgency in a situation where that person in a public place is highly aggressive. A person who is to move to a mental health facility by the police may be taken to a place of safe custody for a period not exceeding forty-eight hours if the person cannot be transferred immediately to a facility.

At decentralised local level Metropolitan, Municipal District Assemblies (MMDAs) are responsible for the wellbeing of persons with mental disorders found in public places in the district. Metropolitan, Municipal District Assemblies should liaise with the police, social welfare and health authorities to remove persons with mental disorders who are a danger to themselves or to others and found in public places in the district to a facility or mental health facility for treatment and rehabilitation. Metropolitan, Municipal District Assemblies have a responsibility of ensuring in consultation with the appropriate agencies that a person with mental disorder found in a public place, after treatment rehabilitated and integrated into the society. Metropolitan, Municipal District Assemblies also make adequate budgetary allocation for the care of persons with mental disorders found in public places within the district.

Potential challenges of the Mental Health Act 846

The mental health Act has become a law in the context where expenditure on mental health continues to dwindle in Ghana. This brings serious challenges, especially in the area of health system challenges (Roberts et al., 2013). For instance, historically, mental health is centred in the curative domain in the way the extension of psychiatric facilities to units regional and districts hospitals is in line with curative framework. The new framework, which centred on community psychiatric, is services from psychiatric facilities, which is not practice before. Ofori-Atta et al., (2010) found that the mental health unit is organisationally place within the institutional care division of Ghana Health Service. The offices are located in Accra psychiatric hospital, which served as a headquarters, which governs the three psychiatric hospitals. Asare (2001) states that, there is no operational link between the Directorate of public health service and mental health unit that could have administrative challenges.

There are also social service challenges, especially as the law mandates community treatment and treatment of mental health at the primary care level. Laird (2008), in a study of the Department of Social Welfare in Ghana on Social Services in Africa found that conditions of services of social services in Ghana cannot support the ability of the social services to provide adequate work forces in the area of Social Workers, Clinical Psychologist who can support implementation of the Mental Health Act. According to Doku, Wusu-Takyi and Awakame (2012), the new Act rather is the duty of the Minister for Social Welfare, which redefines the importance of social support. Community based rehabilitation in Ghana is mainly for the physically disabled without provision for the mentally challenged persons.

Other serious and obvious challenges to psychiatric hospitals are human resource and financial capacities. The new mental health act requires availability of well-trained personnel in the area of Doctors, Nurses, Psychologists Social Workers and others that are inadequate coupled with low motivation in the system. Appiah (2016) reported that psychiatric hospitals in Ghana owed creditors between 2012 and 2015 to the tune of 13 million Ghana Cedis and this debt was because of purchase of medicines, food, facilities, maintenance and others. These resources in short supply were hampering adequate and proper care and treatments of persons with mental health conditions.

Provision of Mental Health Services

In the new mental health Act, there is a provision for a body, the Mental Health Authority (MHA) and the object of the authority in the law is to propose mental health policies and ensure their implementation. Further, the body is to promote mental health and provide humane care, including treatment and rehabilitation in a least restrictive environment; and also promote a culturally appropriate, affordable, and accessible and equitably distributed integrated and specialised mental health care that will involve both the public and the private sectors. Osei (2012) observed that the law made provision for a mental health fund, which mandates fund managers to appoint by the Board. Various sources of funding to be defined by Parliament. Possibilities include allocating a component of existing levies (VAT) or establishing a new levy. Others are to integrate funding for mental health activities into regular cycle of annual government budgeting and the Board may also source research grant and donations from bilateral and multilateral sources and so forth.

The law as well directs a community centred approach to mental health services that is a departure from the existing facility based care. Secondly, it incorporates the informal sector of unorthodox mental health practitioner. According to Osei (2012), Barke, Nyarko and Klecha (2011), there are 70- 80 percent of Ghanaians who utilize unorthodox medicine from the 45,000 traditional healers, located in both urban and rural areas. Most of these healers were identify as well as other numerous prayer camps that attend to the mentally ill, provide of training support and regulate of their practice, including the application of sanctions were proffer should they overstep approved boundaries (Osei, 2012). There has also been provision for integration of mental health care into regular care at the operational levels. Again, training for medical assistants of psychiatry is to be provided and a plan to establish psychiatric wings in all regional and district hospitals. Further, within the Ghana Health Service, appoint a focal person for mental health within its Institutional Care Division.

Mental Health Policies by Wolrd Health Organisation

World health Organisation (2013) developed an action plan for the period 2013 to 2020. This was because of World Health Assembly's resolution at the Sixty-Sixth (66th) World Health Assembly in May 2013. This action plan and strategies have close links with other notable strategies. For example, global strategy to reduce the harmful use of alcohol, the global plan of action for workers' health, 2008-2017, the action plan for the global strategy for the prevention and control of non-communicable diseases, 2008-2013, and the global action plan for the prevention and control of non-communicable diseases (WHO, 2013).

The action plan is design to create interaction with other relevant programmes of organizations in the United Nations system, United Nations inter-agency groups and intergovernmental organizations (WHO, 2013). The focus of the current action plan was to expand services for mental health in low resource settings. The action plan therefore is global in scope and is design to provide guidance for national action plans. It addresses, for all resource settings, the response of social and other relevant sectors, as well as promotion and prevention strategies.

According to WHO (2013), the structure of the action plan is to have a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights. Also, to access high quality of culturally-appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination (United Nations, 2015; WHO, 2013). The overall goal of the action plan is to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders. It has four main objectives among other things; i. strengthens effective leadership and governance for mental health, ii. provides comprehensive, integrated and responsive mental health and social care services in community-based settings, iii. implements strategies for promotion and prevention in mental health; and v. strengthens information systems, evidence and research for mental health.

According to WHO (2013), crosscutting principles and approaches for the action plan seek universal health coverage for all. The first principle states that regardless of age, sex, socio-economic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health. Studies of WHO stated that achieving the right to health is closely related to other human rights, including the right to food, housing, work, education, non-discrimination, access to information, and participation (WHO, 2015). Correspondingly, this action plan reaffirms the sustainable development Goals target 3.8 (Table 1) which seeks to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (United Nations, 2015).

Furthermore, Human rights, which are all mental health strategies, actions and interventions for treatment, prevention and promotion, must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments. According to United Nations (2015), there were evidence of global human right abuse against the mentally challenged. For instance, people are tied to bed, chain, physically abused and in some cases, killed. Human right as a top policy priority of the WHO is very appropriate. According to WHO (2015), the right to health includes both 'freedoms' and 'entitlements' of which freedoms include the right to control one's health and body. For instance, sexual and reproductive rights and to be free from interference which includes, free from torture and from non-consensual medical treatment and experimentation. Entitlements include, the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health including the mentally challenged (WHO, 2015).

The next principle is the use of evidence-based practice, that is, mental health strategies and interventions for treatment; prevention and promotion need to base on scientific evidence and/or best practice, considering cultural considerations. Similarly, Life course approach which looks at policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age. Basic Needs (2014) is currently using community based and people centred approach to help people recover from mental illness.

Commonwealth of Australian (2013) found that the importance of working collaboratively with a person and their family irrespective of whether they are receiving treatment voluntarily or involuntarily, involves self-determination, which is a vital part of successful treatment and recovery, and this re-echoes a person-centred approach espoused in the model of Basic Needs.

Equally in the principle is the multi-sectorial approach, which includes a comprehensive and coordinated response for mental health which requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country's situation. Again, WHO (2014) in a study of Social Determinants of Mental Health, found that mental health and many common mental disorders are shaped to a large extent by social, economic and physical environment in which people live. It added that action to improve the conditions of daily life from before birth during early childhood at school age, during family building and working ages and at old age will improve population mental health and inequalities that are associated with it (WHO, 2014).

The final principle is empowerment of persons with mental disorders and psychosocial disabilities. Psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation. Most health promoters used several models to help individuals take control of their health situation. For instance, Raeburn and Rootman (1998) people centred model of health promotion is to build people capacity to manage and control their own health, which makes citizens partners in the change process.

Similarly, Glover (2012) argued that efforts that people go through in their personal recovery journeys are through a set of five processes i) from passive to active sense of self. This involves moving from the passive position of being a recipient of services to reclaiming one's strengths, attributes and abilities to restore recovery; ii). Also, from hopelessness and despair to that of hope, iii) then from others' control to personal control. In addition, responsibility which involves moving from others taking responsibility for recovery to the person taking, holding and retaining responsibility; iv). Another process is from alienation to discovery, which involves finding meaning and purpose in the journey; doing more of what works and less of what does not; v). Again, from disconnectedness to connectedness which means moving from an identity of illness or disability to an appreciation of personal roles and responsibilities and to participating in life as a full citizen and not through the powerlessness of illness. Glover (2012) added that people need help which demand that services should be provided in recovery constantly 'doing for another' can contribute to a state of impotence and inability. A recovery approach encourages people to take an active role and reclaim responsibility for the direction of their life (Glover, 2012). These models support social support for the mentally ill at the various levels that could help in recovery.

Millennium Development Goals and the Sustainable Development Goals

The Millennium Development Goals (MDGs) came to an end in 2015 and there has been an extensive review and subsequent launch of post 2015 agenda which consist of 17 Goals (Table 1) referred to as Sustainable Development Goals (SDGs). Even though impressive progress was made under the MDGs, a careful review shows that there were areas which needed more attention or has been neglected (WHO, 2015; ICSU & ISSC 2015). A case in point is the progress made on reduction of child mortality and fight against infectious diseases. From science perspectives, ICSU and ISSC, (2015) stated that SDGs offer major improvements over the MDGs.

Other areas of the SDGs which are major improvement over the MDGs are challenge of acute epidemic diseases, disaster and conflict situations as well as the effect of non-communicable diseases and mental health disorders and large inequalities in all parts of the world. All these indicators have been addressed and the new goal for the post 2015 agenda is to ensure healthy lives and promote well-being for all at all ages. The actions have been burdened with 17 goals (Table 1) with 169 targets in the domain of economic, social and environment. Addressing these domains will also mean tackling social determinants of mental health in the world (WHO, 2015).

Key unique feature about the Sustainable Development Goals is its concept and approach in universalism or globally oriented in nature with cross cutting issues which affect almost every country. According to the Secretary General's synthesis report in 2014, message of universality is key and it states that universality implies that all countries need to change, each with its own approach, however each with a sense of the global common good (United Nations 2014). The SDGs is also designed to achieve inter sectorial coherence, global partnership for sustainable development which eventually focuses on the needs of the poor and the vulnerable (United Nations, 2015; WHO, 2015).

Some key Impacts of Millenium Development Goals in Ghana

Global target of halving extreme poverty is achieved ahead of time. For instance, the incidence of extreme poverty (population living below $1.25 a day) was halved by 2011 (United Nations, 2015). Additionally, in the developing countries, the population of extremely poor people is estimated to have reduced from 47 percent in 1990 to 14 percent by 2011 (United Nations, 2015). In Ghana, extreme poverty and hunger was largely achieved by halving it in 2006 and both rural and urban areas were significantly affected positively (Ghana Millenium Development Goals, 2015). Child mortality, universal primary education has largely been achieved with some significant progress in areas such as HIV/AIDS, malaria and other diseases and nutrition among children. Again, halving the proportion of people without access to safe drinking water was also achieved in 2010.

Health Goal and Targets of the Sustainable Development Goals

United Nations (2015) on the 2030 agenda for sustainable development outlined clear health goals and targets. It sets out to promote physical and mental health and wellbeing, and to extend life expectancy for all. Also, the issue of achieving universal health coverage and access to quality health care was also indicated making strong reference to mental health and states that no one must be left behind (United Nations, 2015). Issue of access has been identified as a human rights issue by WHO (2015) that the right to the highest attainable standard of health involves a set of social criteria that is conducive to the health of all people, including the availability of health services, safe working conditions, adequate housing and nutritious foods. Achieving the right to health is closely related to other human rights, including

Table 1: Sustainable Development Goals

1. End hunger, achieve food security and improved nutrition and promote sustainable agriculture.
2. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.
3. Ensure healthy lives and promote well-being for all at all ages

Targets in the Sustainable Development Goals

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births

3.2 By 2030, end preventable deaths of new-born and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

Table 1: continued

3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least-developed countries and small island developing States

3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.
5. Achieve gender equality and empower all women and girls.
6. Ensure availability and sustainable management of water and sanitation for all.
7. Ensure access to affordable, reliable, sustainable and modern energy for all.
8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.
9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation.
10. Reduce inequality within and among countries.
11. Make cities and human settlements inclusive, safe, resilient and sustainable
12. Ensure sustainable consumption and production patterns
13. Take urgent action to combat climate change and its impacts
14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development.
15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss.
16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.
17. Strengthen the means of implementation and revitalize the global partnership for sustainable development

Source: World Health Organisation, (2015)

the right to food, housing, work, education, non-discrimination, and access to information, and participation (WHO, 2015). Another case to support access and universal health coverage is the finding of the United Nations to support mental health disorders that less than 20 percent are able to access services and a strong evidence of treatment gap of up to 98 percent (United Nations, 2015).

The health goal also states a strong commitment to accelerating the progress made reducing new-born child and maternal mortality by ending all such preventable deaths before 2030. Also, commitment to ensuring universal access to sexual and reproductive health-care services, including for instance, family planning, information and education has been stated. Progress made in fighting malaria, HIV/AIDS, tuberculosis, hepatitis, Ebola and other communicable diseases and epidemics, including addressing growing antimicrobial resistance and the problem of unattended diseases affecting developing countries will be accelerated.

There is as well a strong commitment to prevention and treatment of non-communicable diseases, including behavioural, developmental and neurological disorders which have been found to constitute a major challenge for sustainable development. One of the key distinguishing features of the SDGs from the MDGs is the commitment towards addressing issues of mental health and other behavioural, developmental and neurological disorders which have given credence to WHO's Constitution (1946). The targets set (Table 1) for instance, in SDGs, targets 3.4 states that by 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. In target 3.5, strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. Target 3.8 states that achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Key drivers for these targets to address mental health problems according to the United Nations (2015) were that, mental health is recognised to have a high prevalence in the world such that 1 in 4 people experience mental disorders and psychosocial disabilities in their life times. It finds that 85 percent of these groups are in the low and middle-income countries. Also, this situation has been described as a global emergency where human rights violations and discrimination was eminent in the area of chaining and physical abuse of the mentally ill. For example, Lasalvia, Zoppei, Van Bortel, Bonetto, Cristofalo, Wahlbeck, Germanavicius, (2013) found that people with mental health problems frequently experience stigma and discrimination which act as a barrier to accessing health to the extent that in Nepal, mental illness is a legal ground for divorce.

Another evidence of inclusion of mental health targets to the post 2015 agenda is the growing burden of the condition which reduced life span by up to 20 years (United Nations, 2015; WHO, 2015). There has also been considerable proof that there is a cross cutting issue in mental health in the wide range of the sustainable development goals in direct linkage with poverty and other goals. For example, World Health Organisation (2014) on social determinants of mental health opined that certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with gender. This disadvantage starts before birth and accumulates throughout life. Other areas of concern are strong evidence that treatment gap of mental health is about 98 percent in the world and less than 20 percent are able to access treatment which denotes that about 80 percent of those who are mentally challenged are not able to get treatment which further worsens the situation. Likewise, in Ghana, as at 2011, the treatment gap was found to be 97 percent or more of the mentally challenged who could not get treatment (Roberts et al., 2013).

According to International Labour Organisation (2014), social protection policies are significant as they play critical roles in realizing the human rights to social security for all and as well as reducing poverty and inequality. They also support inclusive growth by boosting human capital and productivity, supporting domestic demand and facilitating structural transformation of national economies (ILO, 2014). Even though the need for social protection is widely recognized, the fundamental human right to social security remains ignored for the large majority of the world's population and particularly Ghana. It finds that only 27 percent of the global population enjoy access to comprehensive social security systems, whereas 73 percent are partially covered or not at all (ILO, 2014). Social protection according to International Labour Organisation (2014) (ILO) plays a fundamental role for women and men of working age by stabilizing their incomes in the event of unemployment, employment injury, disability, sickness and maternity, and by ensuring that they have at least a basic level of income security (ILO, 2014). World Bank (2014) also added that people who are not sufficiently protected by social protection schemes and programs live in poverty and this is in the case for half the population of middle and low countries of which Ghana is part.

In Ghana, dependency ratio is very high as every working adult is looking after two or more people and in a situation where unemployment exists, without unemployment benefits will worsen the plight of the poor and this could be a fertile ground for mental challenge (WHO, 2014). According to ILO (2014), where there is an existent of unemployment benefit schemes for people, it plays a vital role in providing income security to workers and their families in the event of temporary unemployment in the informal sector that could cushion family members. International Labour Organisation finds that only 28 percent of the labour force worldwide is potentially eligible for benefits should they become unemployed. Whiles 80 percent of the labour force is covered in Europe in terms of unemployment benefits for instance, only 8 percent is covered in Africa (ILO, 2014).The only unemployment benefit however could be dependency in terms of family system that is, extended. This traditional system, which is utmost resource to Africans however, is gradually being eroded by urbanisation (Bongaart, 2004).

On social protection and disabilities which includes mentally challenged, global estimates put persons with disability at 15 percent of which many of them live in developing countries. Many of this group face greater disadvantage than others in accessing decent work that matches their skills and qualifications and they are more likely to be unemployed (OHCHR, 2012; United Nations, 2013). As a result of inadequate assistance and non-supportive environment, most of these groups are unemployed of which mentally challenged is part. Meanwhile, social protection system is very important in addressing specific needs of persons with disabilities especially with regards to income security, social health protection and social inclusion (ILO, 2014) which enhance social support for the mentally challenged and care. Some key elements of social security systems as opined by ILO (2014) that address disability related needs include schemes or programmes that provide income support to persons with disabilities and their families such as, contributory or non-contributory disability persons' social health protection and other mechanisms to ensure universal health coverage.

National Social Protection Strategy in Ghana

Ghana's National Social Protection Strategy adopts a general and multifaceted approach to social protection where two-tier systems of social protection mechanism have been considered (National Development Planning Commission, 2010). In the first tier, the focus is on chronically poor people who are seen to be automatically vulnerable. The second tier focuses on poor households vulnerable to fall into extreme poverty. The vision for the social protection strategy in Ghana is to have an inclusive equitable society in which ordinary and extremely poor and vulnerable citizens are protected from risks and shocks. They are also empowered with improved capability, to overcome social, economic and cultural challenges in order to realize their rights and responsibilities and to make meaningful contributions to society.

Sultan and Schrofer (2008) explained that social protection strategy of Ghana has three main strategies that tackle extreme poverty. These strategies are; to establish a new social grant scheme to provide a basic and secure income for the most vulnerable households, to better poverty targeting existing social protection programmes and to package complementary inputs. Although there are some existing social protection programmes in Ghana that aim at addressing the needs of the poor, vulnerable and disabled, majority of these programmes do not target and reach disabled and specifically the mentally challenged. Once more, there are many uncoordinated social protection programmes in Ghana.

Linkage between International Laws and Policies on Mental Health

A critical assessment of the international laws reviewed in this chapter and policies showed a linkage between existence of laws, policies and their effects on mental health. International laws and policies promote for instance the right to mental health and recognise that certain socio-political and economic conditions are essential for effective population mental health (WHO, 2005). International laws also include enjoyment of civil, political, economic and cultural rights as stated and directed in the International Bill of Rights. For instance, International Covenant on Civil and Political Rights, WHO (2005), found that there should be a need of vulnerability and poverty and therefore requires countries to recognise the need for the vulnerable groups. This should also guide government for creating the social, economic and political conditions to promote mental health.

Gostin (2001) found that human rights violations can be harmful and have consequences on mental health of the population of which the evidence is clear and as mentioned earlier, one of the driving forces of giving attention to mental health in the SDGs (United Nations, 2015). Torture and other forms of inhuman and degrading treatment according to Gostin (2001) is seen to have adverse effect on mental health of people. For instance, rape, domestic violence and other physical and psychological abuses against women could result in poor mental health.

Furthermore, there is a strong association between mental well-being as well as physical well-being and issues in unemployment, low level of education and lack of food, shelter and access to health care (WHO, 2005). Fryers, Melzer, Jenkins and Brugha (2005) reviewed a population in a study conducted in European countries and found that higher frequencies of common mental disorders (depression and anxiety) were associated with low educational attainment, material disadvantage and unemployment, and for older people, social isolation were found. Other areas that have direct linkage with mental health, and negatively affect the population are; the restrictions in the rights to vote, to take part in public affairs, to express one's opinion, seek information and freedom of association.

Gostin (2001), asserted that international laws however provide a kind of cover for mental health promotion. For instance, the Universal Declaration of Human Rights, the International Covenants on Economic Social and Cultural Rights and International Covenant on Civil and Political Rights have an imposition of a legally binding obligation, especially in the ICESCR and ICCPR on member states to respect, protect and fulfil human rights conditions within them. For example, the Committee on Economic, Social and Cultural Rights reiterates the need for countries to consider the underlying determinants of health and to adopt measures to promote a range of civil, political, economic, social and cultural rights as contained in the International Bill of Rights. These include the right to life, food, housing, work, education, participation, the enjoyment of the benefits of scientific progress and its applications, non-discrimination, equality, prohibition against torture, privacy, access to information, and freedom of association, assembly and movement.

Hunt (2003) argued that social inequalities driven by discrimination and marginalization of particular groups shaped both the distribution of diseases and the course of health outcomes amongst those afflicted. As a result, the burden of ill-health is borne by vulnerable and marginalized groups in society. Similarly, discrimination and stigma linked with particular health conditions, for example mental disabilities and diseases like HIV/AIDS, tend to reinforce existing social divisions and inequalities (Hunt, 2003).

The International policies and laws have had a great impact on health and will as well have on that of mental health as set in the SDGs and other international laws than even the local policies and laws. For example, the UNCRPD makes community treatment and rehabilitation for persons with mental disability mandatory and binding (UN, 2006) which has reflected in the mental health Act 846, 2012. Likewise, the MDGs which came from the Millennium Declaration, signed by 189 countries, including 147 heads of State and Government of which Ghana was part in September 2000, have contributed immensely to changing the way we think and talk about the world, shaping the international debate on development, and stimulating popular awareness of moral imperatives such as achieving gender equality and ending poverty and starvation (WHO, 2015). An evidence of contribution of MDGs to development is progress made in income poverty, access to improved sources of water, primary school enrolment and child mortality.

The MDGs have also contributed significantly to increases in development assistance. For instance, there has been evidence that 66 percent jumped in official development assistance (ODA, in real terms) between 2000 and 2014 when it reached an unprecedented US$ 135 billion World Bank & WHO, 2016; WHO, 2015). Mathers, Stevens, Boerma, White and Tobias (2015) found that there has been quite considerable aid flowed into education and public health, while also being directed towards poorer countries to supplement the increases in domestically sourced development finance. The influence on donor policies and practices and on governments in the developing world has been significant (Prince, Wu, Guo Robledo, O'Donnell, Sullivan &Yusuf, 2015).

Equally, the Sustainable Development Goals as adopted on 25 September 2015 by UN General Assembly on the theme "Transforming our world: the 2030 agenda for sustainable development" like the Millennium Development Goals has been described by WHO (2015) unprecedented scope and ambition, applicable to all countries, and goes well beyond the MDGs. It has also linkage with WHO global action for mental health which focused on expanding services for mental health in low resource settings and to have a world in which mental health is valued, promoted and protected (WHO, 2013). The worlds' view of health, according to United Nations General Assembly's Resolution, which is a fundamental assumption of the SDGs, is that, health is a major contributor and beneficiary of sustainable development policies. The health goals featured prominently issues on mental health as reflected in targets 3.4, 3.5 and 3.8 and its linkage to other targets. Since these policies are international in nature, and have attracted donor funds as well as international monitoring, it could rather lead to giving attention to mental health in Ghana significantly as evidenced by the MDGs.

Summary

This chapter reviews international laws and policies as well as strategies, which offer very useful direction and guidance for mental health and recognise mental health as basic human rights. The United Nations Universal Declaration of Human Rights for instance, looks at dignity and human rights that positively affects the new Mental Health Act of Ghana. In addition, the International Covenant on Economic, Social and Cultural Rights directs State Parties to make sure the right of everyone to attain the highest standard of physical and mental health is realised. World Health Organisation's Constitution also recognises mental health as a component of health without which full health cannot be achieved as well as recognising health as some fundamental human rights. Further, African Charter on Human and Peoples Rights reaffirm regulations on health and people's rights including the right to mental health.

Besides, United Nations Conventions touched on the rights of persons with disabilities and issues of discrimination. The chapter also review various laws that were enacted in Ghana including Ghana's Constitution, Mental Health Ordinance of 1888, and Mental Health Act 846 which came into force adopting human rights approach and following international standards. Over again, various health and development oriented policies were reviewed as well as social protection system in Ghana. The chapter also draws a linkage between mental health and international laws and policies. From these the chapter concludes that like the Millennium Developments Goals impact on poverty, maternal and child health in Ghana, Sustainable Development Goals which now gives attention to mental health could rather have a significant impact on mental health delivery in Ghana rather than the laws enacted to protect the mentally challenged of which were in existence for some time now including the Constitution of Ghana.

CHAPTER THREE

REVIEW OF EMPIRICAL LITERATURE

Introduction

This chapter examines types of social support and its influence on mental health. It also explores the burden or constraints by caregivers, both formal and informal in caring and providing for the mentally challenged. It concludes on key groups of variables that guide the work.

Types of Social Support

There are three types of social support as depicted in figure 1. These are; functional, structural and negative support which are discussed.

Functional Social Support

This is a qualitative approach, focused on various supportive functions such as emotional interest (love, friendship, empathy) and instrumental or material aid or the degree to which interpersonal relationship serves a particular function (Figure1). Emotional support refers to the show of love and caring, esteem and value, encouragement and sympathy (House & Kahn, 1985). Similarly, informational support is the provision of facts or advice that may help a person solve problems. It also includes appraisal, feedback about ones' interpretation of a situation and a guidance regarding possible causes of action (Mattson & Hall, 2011). For instance, an individual with depression needs more information about his/her condition and treatment options, which could receive support by those who provide useful information. Instrumental support, which is also referred to as material assistance, could also offer or supply behavioural assistance. It also describe as actual support, which is the support that an individual receives in terms of what is receive and what is done for an individual who may be in trouble.

The debate on perceived and actual support shows that one's perception of a support is more effective compared to the actual support received. For instance, it state that an anticipation that support is available or will come could have a positive effect on health and well-being because one is able to redefine the situation as less threatening (Cohen & Wills, 1985). In addition, perceived support according to Norris and Kaniasty (1996) is an individual's belief that support is available or anticipation that support is available when needed. For instance, research suggests that perceived social support is associated with improved physical and mental health (House, Landis & Umberson, 1988), and that perceived support is more essential than received support in predicting adjustment to life stress.

A survey by McDowell and Serovich (2007) compared the ways perceived and the actual social support that affects the mental health of men and women living with HIV/AIDs. It established that for all those involved in the study, perceived social support predicted positive mental health while the effect of actual social support on their mental health was minimal. Similarly, Tam (2008) conducted a study on 378 undergraduates from University Tunku Abdul Rahman and Sunway University College, Malaysia, and found that adolescents who perceived higher social support from family and friends had higher level of competence and self-esteem. It suggests that despite the different ethnic groups and culture in Malaysia, social support plays an important part in developing an individual's coping capability. Tam (2008) suggested therefore that good relationships among siblings and parents indirectly would provide more perceived social support.

Another study on the field of received support has shown that receiving social support can also have positive effect on recipients' health and well-being. Other studies have specified that receiving supportive behaviours from one's spouse was related to lower levels of distress (Druley & Townsend, 1998; Frazier, Davis-Ali, & Dahl, 1995; Schuster, Kessler, & Aseltine, 1990). Also, partner support enhanced the coping ability and wellbeing of cancer patients but worsened for unsupported patients. Other works in the field of social support show positive main effect of receiving social support. For instance, Schulz and Schwarzer (2004), found that provided emotional, informational and instrumental support correlated moderately with received emotional support.

Structural Social Support

Structural support on the other hand, looks at the extent of an individual's social integration or the existence and quantity of social relationships (Lourel et al, 2013). For instance, marital status, group membership, number of friends one has and number of potential support available to individuals. Berkman and Glass (2000) assert that the level of integration in a social network have a direct effect on well-being regardless of the presence of stressful circumstances. This is explain further that social ties influence health behaviour, in some forms for the reason that they influence health by controlling one's habits (Umberson & Montez, 2010). For instance, a spouse may monitor, inhibit, regulate, or facilitate health behaviours in ways that promote a partner's health (Waite, 1995).

The World Health Organisation (2005) for instance asserted that one of the aspects of good mental health is the ability to mutually satisfy and endure relationships. The intermediate body has noted that social relationships and networks act as protective factors against the on-set and recurrence of mental ill health. Additionally, interactions enhance recovery from mental disorders. Equally, development of infants are link to social interaction and development of children is not complete without social support (WHO, 2005). According to the Parkinsonian (2016), seeking social support is a strategy that could help with depression and might play an important role in lessening the degree of depression. It helped in creating more fulfilling social relationships and learning to enjoy time alone. There have been suggestions of owning a pet and exploring new interests and hobbies such as joining support groups, clubs and other organisations in a way of strengthening one's relationship, which improve Parkinson diseases, which has linkages on mental health outcome.

Negative Social Support

This is sources of psychological stress with detrimental behavioural and physiological consequences for health (Cohen, 2004). Rook (1984) found that there is a need to attend to negative aspects of social support as well as positive aspects, which will allow for a deeper understanding of social ties and its respective influence on health. This concept focuses on the existence of both conflicts and dissatisfaction with social relationships and of social isolation and lowliness. Exposure to adverse exchange relationships with high levels of conflict may induce psychological distress, which has adverse effects on health (Cohen, 2004). Negative social interactions have been link to poor psychological outcomes, including greater depressed mood.

Social Support		
Structural	Functional	Negative Support
Group membership Network size Number of friends Frequency of contacts Network density	Actual support Perceived support Instrumental support Emotional support Informational support Social companionship Appraisal support	Dissatisfaction Interpersonal conflict Insensitivity Interference Social undermining Non-conformity in a group Cultural differences

Figure 1:Authors Compilation on Types of Social Support Adapted from Different Sources.

Negative social interactions may also be linked to increased hypertension risk through their effects on health behaviours. By increasing psychological stress, negative social interactions may promote harmful coping behaviours, including increased tobacco and alcohol use and physical inactivity (Cohen, 2004).

Isolation could be a stress factor, which increases regulative affect as well as a sense of alienation, which accounts for a low self-esteem in individuals. Cohen (1988) found that when individuals are in regulative psychological state, they are bound to experience increased neuroendocrine and cardiovascular responses, which suppresses immune function and interferes with performance of health behaviours. A further explanation to this has been given by Parkinsonian (2016) that when people are exposed to stress, emotional support reduces the rise of blood pressure and the increased secretion of damaging stress related hormone. Umberson and Montez (2010) discovered that captors use social isolation for instance, to torture prisoners of war and this form of isolation of healthy individuals could result in psychological and physical disintegration that could result in death. This has also recalled the study by Durkheim (1897) on integration and isolation with its results being abnormal behaviour, suicide, and stable societies.

Socio-Demographic Determinants of Social Support among the Mentally ill in Ghana

A number of socio-demographic variables are reviewed which could have determined availability of social support. These are; age, gender, education, employment and income. The rest are; marital status, family system, place of residence, religion and so forth. Whether people are employed, married, attend church, belong to organisation or have frequent contact with friends and relatives which is a resource and the nature and quality of those relations are determined by socio-demographic variables (Rousou, Kouta & Middleton, 2016).

Age

According to World Report on Disability (2015), disability is part of the human condition, which everyone will be temporarily or permanently impaired at some point in life, and those who survive to old age will experience increasing difficulties in functioning. World Health Organisation (2017) on the 'Key Facts' found that globally, the population is ageing rapidly and projected that between 2015 and 2050, the proportion of the world's population over 60 years will nearly double, from 12 to 22 percent. Mental health and emotional well-being are very crucial in older age as at any other time of life. Neuropsychiatric disorders among the older adults account for 6.6 percent of the total Disability Life Years (DALYs) for this age group.

World Health Organisation (2017) report on aging stated on conditionality that if people were experiencing additional years of life in good health, then their ability to do the things they value would have few limits. On the other hand, if these added years were dominate by declines in physical and mental capacities, the implications for older people and for society may be much more negative. It is at this stage that social support becomes crucial for the older people with mental health problems. The World Bank (2012) report on Elderly and old age support in rural China asserted that between the ages of 60 and 70 rural household support shift from primary reliance on labour income to primary reliance on family support. However, Cain (2012), observed that marginalisation of older people and those with disabilities or mental health issues is being fuelled by prevailing attitudes, stigma, environmental barriers, difficulties in accessing social services, and lack of voice and participation, all combine to render these groups 'invisible' (Cain, 2012).

Meanwhile, evidence from a study by Carstensen (1986) suggested that increased social activity proved beneficial to psychological wellbeing, which is more likely to be generalised to middle-aged adults. Nonetheless, people maintain social connections with numerous others throughout life. However, during the latter part of adulthood, rates of social interaction begin to decline. Later-life relationships become fewer in number, but deeper in intensity and quality (Carstensen & Fredrickson, 1998). Similarly, Lowenthal and Haven, (1998), in a study on social interaction and adaptation have shown that, for older persons in particular, reporting a stable intimate relationship is more closely associated with good mental health and high morale than higher numbers of social interactions or higher socioeconomic status. Thus, even a comparatively small number of social ties can yield a high level of psychological wellbeing if a few, more intimate relations exist (Lowenthal & Haven 1998).

In a related study that gave more illustration to the issue by Antonucci, Fuhrer and Jackson (1990) as well as Carstensen (1991), aging tends to be associated with a shrinkage of the social network, and both support 'receiving' and support 'giving' have been found to decline as age increases, with the greatest amount of support being given to one's network in midlife. Other differences were in the composition of family and friends in networks: younger adults were found to include fewer family members and more friends in their support networks than older adults (Levitt, Weber, & Guacci, 1993). A further analysis of life span and various social supports by Okun and Keith (1998) show that these supports are relative according to age. For instance, support from sources such as spouses, children, and other relatives/friends was predictive of low levels of depression for older adults.

There is evidence that the type of support (e.g., family, friend) may have differing age-dependent effects. This, Okun and Keith (1998) found that only support from one's spouse was predictive for younger adults. Furthermore, they found that, whereas strain from the spousal relationship predicted depression for both age groups, strain from children was predictive only for older adults. Carstensen (1991) suggested that even though older adults may report fewer networks or friends, its effect is great in reducing stress in adults as described as regulating emotions (Carstensen, 1991). Gupta and Korte (1994) further saw network of friendship to be more relevant than family networks to adults especially their morale support. This is because family members become less available as results of death of a spouse or family members. Also, older adults are more likely to confide in peers, and such peers are preferred sources of support for situations in connection with aging process such as death of a spouse. This friendship could be seen as providing support equalling what family members used to provide and this could become a commitment that is seen as obligatory (Adams & Blieszner, 1994 :1995; Wood & Robertson, 1978; Wright, 1990).

The general observations that as people age they will have less social interaction (Lowenthal & Haven (1998)). A good mental health in the aged relate to a very high social support even if one is aged. Those who have mental health problems could have been because of poor social support. Nonetheless, the attitudes of families towards treatment and care are changing. Once more, what was previously considered the normal results of ageing is seen as the result of illnesses, deprivation externally or internally inflicted abuse and therefore avoidable (WHO, 2005). Copeland (2003) stated that, depression and dementia is a major mental illness affecting old people.Meanwhile, in developing countries, Patel and Prince (2001), revealed that the elderly face a triple burden in developing countries which include a rising tide of non-communicable and degenerative disorders associated with ageing, falling levels of family support and lack of adequate social welfare systems (ILO, 2014). Concepts of mental health regarding quality of life to older people do not differ significantly from those of younger people. Differences in behaviour however are the result of physical or mental disease or social disadvantage rather than the ageing process itself. For example, elderly people have to contend with real issues of lack of financial and social support, isolation or increased responsibilities in caring for grandchildren in the case of HIV/AIDS.

Exercise is a form of social support engaged by the elderly, typically in the Asian countries, which could bring about positive mental health outcome. For instance, Fletcher, Breeze and Walters (1999) stated in a study that exercise, such as aerobic classes, and weightlifting, does provide psychological benefits including reduced depressive symptoms and increased mental well-being in clinical and non-clinical elder populations (Deuster, 1996; Fletcher, Breeze & Walters, 1999; Singh, Clements & Singh, 2001).

In Taiwan, physical exercise, specifically 't'ai chi', (usual exercise and entertainment activities) is widely practiced by elders as a culture. Chen, Snyder and Krichbaum (2001) conducted a cross-sectional, comparative study to explore the differences in physical and psychological well-being of Taiwanese community- dwelling elders who had practiced 't'ai chi' for one year or longer with those who did not practice 't'ai chi' or exercise. The results showed that those who practiced 't'ai chi' had better physical and mental health status, lower blood pressure, fewer falls within the past year, less mood disturbance and more positive mood states than those who did not. Similar results were found in a Chinese cross-sectional study in Macao (Ning, 2001). Physical exercise among the elderly contributed independently to the prediction of the depressive symptoms measured by the Chinese Centre for Epidemiological Studies-Depression Scale (CES-D). Even more convincing are the outcomes of an RCT on the impact of a six-month 't'ai chi' exercise programme performing slow rhythm movements.

Results indicated that elderly people who participated in the programme showed higher levels of health perceptions, life satisfaction, positive affect and well-being and lower levels of depression, negative affect and psychological distress than controls (Li, Duncan, Duncan, McAuley Chaumeton, & Harmer, 2001). This could be as a result of engaging older people in a group which is a good source of making friends which inturn reduces lowliness that could have positive effect on mental health. The World Health Organisation (2014) on social determinants of mental health, stated that life events that can activate depression could be experienced in older age such as bereavement, perceived loss of status and identity, poor physical health, loss of contact with family, friends, lack of exercise and living alone.

Gender

There have been various discussions in the literature on gender differences in social support and social networks (Simon, Chen & Dong, 2014). For instance, Bell (1981) found that throughout the life-cycle, women generally have more close friends than men. From childhood, girls tend to develop more intimate interpersonal relationships than boys, while boys tend to team together in larger groups (Bell, 1989). Adult women still have a greater number of close relationships and also seemingly more extensive social networks than men. This is because Barbee, Cunningham, Winstead, Derlega, Gulley, Yankeelov and Druen, (1993), found that women are more likely to be involved in exchanges of emotional support outside the nuclear family than are men. Aukett, Ritchie and Mill (1988) argued that women's relationships depend on emotional closeness, while men's relationships focus on shared activities. This suggests why women may be more likely than men to exchange emotional support. This could also be inferred that in support seeking, women could be verbal and direct compared to men who could be nonverbal and indirect.

Further, women provide more emotional support to both men and women, and they get more help in return. As described by Thoits (1995), women have more propensity to seek for support than men. Explanations for such discrepancies focus on gender differences in emotionality and emotional expressiveness. This proposition could give more social resources to female that are mentally challenged (mental disorders) compared to men since female have more social network than men. In further explanation of this proposition and assumption, Simon, Chen and Dong (2014) argued that the nature of social interaction is different between men and women. For instance, in a family system women are often seen to be kin keepers and take on the main responsibilities of household chores while men are seen as breadwinners. They found that the lifelong investment women make in relationship with family members may lead to more support available in their life and at the time they even have stress.

In the aspect of perceived social support, it has been argued that gender plays a significant role. For instance, Sharir, Tanasescu, Turbow and Maman (2007) found in a study of quality of life in psychiatric patients that females are more likely to receive social support from friends and significant others than males. They draw on number of visits as well as duration which women receive from their friends compared to that of males. For instance, a mental health patient at a psychiatric hospital who receives a longer visit could be an indicator to the patient of the amount of care and support the friends are providing. The longer visits with more words and feelings as well as thoughts can be exchanged, which could make the whole visit significant in this case to females who receive more of such visits and thereby promote better coping among them.

In other development, research found that the buffer effect in social support in females seems stronger than that in males (Sexton, Søgaard & Olstad, 2001). Although these findings could be possible, females have also been reported in studies that report more depression symptoms than males when they experience a lack of social support (Slavin & Rainer, 1990) but profit more for support when it is available (Taylor, Klein, Lewis, Gruenewald, Gurung & Updegraff, 2000).

Income, Education and Employment levels

According to WHO (2014), mental health and many common mental disorders are shaped to a great extent by the social, economic and physical environment in which people live. Social inequalities are associated with increased risk of mental disorders. De Menil, Osei, Douptcheva, Hill, Yaro, and Aikins, (2012), in their study in some selected community of Ghana on women for example showed associations between physical and mental health with education, income number of children and unemployment. There are same study results for example that affirm the assumption of a positive association of socioeconomic position with social networks. For instance, German welfare survey stated that the number of close ties increases with level of education (Diewald, 1991).

Also, Patel, Araya, de Lima Ludermir and Todd (1999), found in a study that mental disorders are about twice more frequently among the poor than among the rich. For example, they found evidence, which indicated that depression is about 1.5 to 2 times more prevalent among low-income groups of could make the whole visit significant in this case to females who receive more of such visits and thereby promote better coping among them.

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Also, Patel, Araya, de Lima Ludermir and Todd (1999), found in a study that mental disorders are about twice more frequently among the poor than among the rich. For example, they found evidence, which indicated that depression is about 1.5 to 2 times more prevalent among low-income groups of populations as well as people experiencing hunger or facing debts. These groups are more likely to suffer from mental disorders, which also affect immensely social support availability for the mentally challenged. According to Campion, Bhugra, Bailey and Marmot (2013), evidence existed that common mental diseases such as depression and anxiety, are distributed according to gradient of economic disadvantage across society. This affects the poor and disadvantaged people and other consequences suffered. Also, a systematic review of the epidemiological data on common mental disorders and poverty in low and middle-income countries found that, of 115 studies reviewed, over 70 percent reported positive association between a variety of poverty measures and common mental disorders. Likewise, population study in England, Wales and Scotland found that the more debt people had, the more likely they were to have some form of mental disorders even after adjustment for income and other socio-demographic variables (Jenkins, Bhugra, Bebbington, Brugha, Farrell, Coid, Fryers, Weich, Singleton & Meltzer, 2008).

Additionally, a review of population surveys in European countries by Lehtinen, Sohlman and Kovess-Masfety (2005) discovered that communities where there were higher occurrences of common mental disorders (depression and anxiety) were associated with low educational attainment, disadvantage in material and unemployment and also found that in older people, there was social isolation (WHO, 2013) which could still contribute to depression. Also, on socioeconomic determinants of mental health, epidemiological studies on distribution of positive mental health in Europe showed that from Euro barometer survey in 2002, a significant variation in population with mental health between countries and between men and women within countries had poorer mental health found in women who reported weak social support (Lehtinen, et al., 2005).

Two-way relationship was as well found between mental disorders and socioeconomic status where mental disorders and socioeconomic status lead to reduced income and employment, and in turn increases the risk of mental disorder (WHO, 2014). According to World Bank and World Health Organisation (2016), failure to treat mental health disorders can lead to diminished economic growth and social well-being at the natural level. There have been reasons for these, which are; that the loss of economic output caused by untreated mental disorders as a result of diminished productivity of work, reduced rates of labour participatory forgone tax receipts and increased welfare payments (World Bank & WHO, 2016). This in most African countries will lead to a high dependency on families which will eventually create vicious cycle of poverty.

Evidence on education and mental health outcome showed that illiteracy or poor education is a consistent risk factor for common mental disorders. Araya, Rojas, Fritsch, Acuña and Lewis (2001) found that the relationship between low educational level and mental disorders may be explained by a number of ways which has been explained to include malnutrition that impairs intellectual development leading to poor educational performance and poor psychological development. Similarly, Lipman, Offord and Boyle (1996) found that the risk of low income for childhood psychiatric disorders is strongest for conduct disorders which are associated with school failure and common mental disorders in adulthood. It is as results of these that the WHO (2014) posited that life course approach in understanding social determinants of mental health is very fundamental. This includes prenatal, pregnancy and early childhood, adolescence, working and family building years, as well as older ages which also have linkages with gender (WHO, 2014).

The social consequences of education have been found to lead to a diminished opportunity for persons to access resources to improve their situation (Hussain, Creed &Tomenson, 2000). This could have a linkage on the mentally challenged whose level of education is low leading to low level of resources, including social capital which could affect immensely their social support, especially at hospitals or in their communities. This situation has been corroborated by Eng, Rimm, Fitzmaurice and Kawachi, (2002) that, social isolation and social stress which is a form of functional support leads to poor health while social participation enhances health. In Ghana for example, De Menil et al., (2012) found that research on Ghanaian women on determinants of health suggest that a complex range of factors impinge on their mental health of which poverty, burden of paid work and others were found to be factors that impinge on women mental health.

Indications on employment and mental health showed that epidemiological investigations in many developing countries that have high rate of common mental disorders are due to discrimination, unemployment and living through social change (Rumble, Swartz, Parry & Zwarenstein, 1996). It is predicted that the decline of social cohesion as a result of social change could lead to structural unemployment which will lead to part-time insecure and low paid employment which could widen the gap between the poor and the rich. This was explained by Zubrick, Silburn, Burton and Bair (2000), as leading to family breakdown, child abuse, and early school failure with serious negative effects on mental health of children and young people. An instance drawn by WHO (2014), on employment issues and mental disorders showed that unemployment and poor-quality employment are particularly strong risk factors for mental disorders and are important cause of inequalities in mental disorders. According to a recent report by Institute of Health Equity on health impacts of economic downturns, it suggested close associations between job loss and symptoms of depression and anxiety (WHO, 2011).

Employment equally in poor nature with no or short-term contracts and jobs with low rewards and control at work have had harmful impact on mental health whiles job security and a sense of control at work are protective of good mental health (Anderson, McDaid, Basu & Stuckler, 2011; Bambra, 2010). For instance, data analysed by European Union and countries over the period of 1970-2007 showed that every one percent increase in unemployment was associated with a 0.79 rise in suicide at ages younger than 65 years (Stuckler, Basu, Suhrcke Coutts, McKee, 2009).

The importance of employment as determinant of mental health has been enshrined in the international laws and policies as well as the mental health Act in Ghana which states that a person with past or present mental disorder shall not be subjected to discrimination and, whatever the cause, nature or degree of the mental disorder, has the same fundamental rights as a fellow citizen (Mental Health Act, 846 (2012). A tenant or employee who develops mental disorder shall not be evicted from the place of residence of that person, or dismissed from the place of employment of that person on the basis of mental disorder. A close linkage exists between one's educational level, employment and income level and influence on mental health as it affects significantly resource availability when one is mentally challenged.

The Human Development Report (2015 p.1) on importance of work stated that ''Work enables people to earn a livelihood and be economically secure. It is critical for equitable economic growth, poverty reduction and gender equality''. It also allows people to participate in society while affording them a sense of dignity and worth. Work is also a valuable supporter of our mental health. It gives structure and rhythm to our daily lives, it gives the possibility for self-fulfilment, it strengthens our self-esteem and it provides security and an opportunity for satisfying relationships (WHO, 2005). The Sustainable Development Goal 8, further recognised the importance of work that state parties should promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all (United Nations, 2015). A higher level of education could lead to better jobs with good pay, which could increase one's resources both socially and in material terms and availability of many resources, could enhance ones coping even when one has this condition.

Marriage

House et al., (1988) found that married people have more benefits in terms of health. Folkman (2001) found that there are detrimental effects for people who unfortunately are widowed or those separated. Berg and Upchurch (2007) corroborated this that the interactions between spouses are more frequent and intense than those with other members of the social network, and the provision of support from the spouse during illness is associated with better adjustment in the patient. Uchino (2004) suggested that the spousal support helps patients to have control over diseases. Durkheim's assertion according to Faris

(1934) saw unmarried and more socially isolated people have manifested regular rates of psychiatric disorders such as schizophrenia. Social resources could be enough among marital unions as compared to people who are not married.

De Vaus (2002) investigated the mental health of 13,000 men and women in older middle age. When for instance race, education, family structure, income and living arrangement controlled for and found that married people were less depressed and emotionally healthier than singles. Moreover, that married women were only half as likely to evaluate their emotional health as being poor. Similarly, a study of 80,000 suicides in the U.S., by Jack, Smith, Mercy, Judith, and Conn (1988) revealed that widowed and divorced persons were about three times as likely to commit suicide as people who are not married. In all, married men only half as likely as single men take their own life. Married women were also significantly less likely to commit suicide compared to divorced, widowed or never married women. Reasons for positive health outcome for spouses explained in young adults who reduce heavy alcohol consumption as well as reduction in marijuana which are life styles that contribute to mental illness.

There has also been another study by Coyne, Rohrbaugh, Shoham, Sonnega, Nicklas, and Cranford, (2001) on Survey of Mental Health and Wellbeing of 10,641 Adults Australians. The study found that married people were the least likely to suffer from any particular class of mental disorder ($p<0.001$) pertaining to mood, anxiety, drug, alcohol, and "any" mental disorder. However, the divorced and separated adults were the most prone to mood and anxiety disorders, and those never married adults were the most at risk of drug and alcohol disorders. Researchers concluded that marriage seems to have the same mental health effect on both men and women and that it is in the direction of protecting them. From this evidence, mentally challenged in Ghana who have spousal support in their difficulties could cope and develop resilience through their healing process which could lead to fast recovery.

Burman and Margolin (1992) found in a study that stress/social support hypothesis is intimate relationships; likely source of support as well as possible stressor. This could be a key driving force behind success related stories relating to good health in marriage. Using a variety of health outcomes, research operating from this perspective have consistently shown that marital supports and stressors not only help to explain health differentials among married individuals but also help to condition the marriage benefit. For instance, marital supports and stressors have been associated with metabolic syndrome (Whisman, Uebelacker, & Settles, 2010), blood pressure (Holt-Lunstad, Birmingham, & Jones, 2008), self-reported health (Umberson, Williams, Powers, Liu, & Needham, 2006), and psychological distress (Whisman & Kaiser, 2008).

Family System

The best source as well as the greatest source of social support and comfort in difficult times is normally from the family members (Fournier, 2011). The importance of family demonstrate, as a primary source of support, is very crucial in the lives of people who are ill.

In Taiwanese context for instance, there is a concept referred to as primacy of family in the life of individuals, which significantly affect social support of individuals. According to Lamley (1981), Taiwanese had a system of patriarchal/ patrilineal kinship system, which had prevailed among them and likened to Chinese system where individuals existed completely in familial context. This compels individuals to have rights only towards their respective families (Fricke, Chang & Yang, 1994). Inter-generational relationships within the family governed by strong norms of filial piety where children's relations with parents are subservient in nature (Ikels, 1993; Fricke et al., 1994). There are a reciprocal relationship between parents and children, where children in particular are to respect their fathers throughout lives. Parents in this system are supposed to provide care for children when they were young and when their parents get old they also provide support for them which is a moral obligation. This system as well is not different from Ghanaian values and culture in the traditional system and especially the extended family in Ghana. However, where there is rural and urban drift, family resources in terms of availability of persons in the family to assist and support the aged or the sick in this case mentally challenged is affected. Bongaarts (2004) said the basic function of a family, which is support for the aged in the past, is changing globally.

Nonetheless, important roles played by families in the area of support are insurance and credit to their families (La Ferrara, 2007). These roles feature prominently in societies that are poor and vulnerable to economic shocks. In industrialised countries, a study by Bentolila and Ichino (2006) on how families coped with unemployment is in the area of generosity, which involves unemployment benefits by sending transfers to family members affected by the shocks.

Liddle (2004) compared family based treatment with alternative interventions in clinical trials and found that in majority of the studies, family-based treatment was superior. It also noted that the outcome was stable and reduced significantly target symptoms of alcohol and drugs.

This approach has resonated with the second objective of the WHO's Action Plan of 2013 to 2020 on comprehensive, integrated and responsive mental health and social care services in community-based settings (WHO, 2013). This approach is emphasising community and family involvement in mental health delivery that could promote interaction of family and community with mental health patients that could enhance resource promotion. Four main reasons (Wynaden & Orb 2005) why some families may be committed to caring for their mentally ill family members were family's obligation to care and protection of vulnerable members. Others are self-reliant nature of families and difficulties families face. Wynaden and Orb (2005) found that family is a great reliable resource as they provide food, support and rehabilitation for the sick family member with others such as physical needs and financial resources. This has also demonstrated the importance of family inclusiveness in treatment of mentally ill without which social resources and other financial needs will be difficult in treatment of the patients.

Duration of stay at the Hospitals

Long treatment cost becomes a problem and some patients are very far from home, which makes it very difficult to receive visitors from their social network, which results in support (McCorkle, Rogers, Dunn, Layass & Wan, 2008). Again, McCorkle et al. (2008) affirmed that the importance of social networks in providing social support at the time of psychological crisis is very important to the healing of patients. It will be difficult for individuals to reintegrate into community after hospitalization (McCorkle et al., 2008). This is because the friends of network have been broken and sometimes forgotten.

Religion/Spirituality

According to Chartters (2000) the doctrine of religion could support positive views of human nature which could be associated with better physical and mental health outcomes.Individual's belief system as well as value system may promote feeling of self-esteem. One's religious affiliation may shape inter-personal behaviours and attitudes in a manner that may promote positive relationship. According to Smith (2003), to be fully human includes the spiritual dimensions of life. It asserted that spiritual wellbeing includes a component of mental health and makes important contribution to quality of life of many people all over the world (WHO, 2005). World Health Organisation observed that 'spirituality can exist independently of religious practice or affiliation, but in most people, their spirituality is found in a religious context'. Koenig, McCullough and Larson (2001) found in clinical and epidemiological studies that spirituality could help prevent depression. For instance, spirituality can provide hope to people in despair, which could prevent suicide and this is a decision that life is not worth living. Again, considerable number of studies on the role of spirituality/religiosity in preventing alcohol problems found in one of the studies that in inner-city, African- American adolescents, who had a sense that they were "working closely with God" had fewer alcohol problems than those who did not have such a belief or experience (Goggin, Murray, Malcarne, Brown, & Wallston, 2007).

Pardini, Plante, Sherman and Stump, (2000) found in a study of 237 recovering substance abusers that higher levels of religious faith and spirituality predicted a more optimistic life orientation, greater perceived social support, higher resilience to stress and lower levels of anxiety. For instance, Underwood and Teresi (2002), conducted interview about the role spirituality played in their daily live and found that people reported being able to experience deep peace even in the midst of mental distress. Spirituality can enable people to step outside or beyond the mental distress and experience comfort and calm. Especially, in the midst of crisis, particular kinds of spirituality can prove to be a powerful resource, which can be a real buffer against excessive mental distress and despair (Pargament, 1997). Religious social networks may also affect health. Krause and Ruxton (2002) explored the relationship between health and the spiritual and emotional support provided at church. They found that attending church more regularly correlated positively with feeling that the congregation is more cohesive and with feeling closer to God. For instance, older persons who report feeling closer to God are more optimistic and have better self-reported health outcomes.

Apart from Christianity, some other studies have corroborated earlier findings on religion and mental health. For instance, on Islam (Abu-Rayya, Abu-Rayya & Khalil, 2009), Judaism (Rosmarin, Pirutinsky, Pargament, Krumrei, 2009) and Hinduism (Tarakeshwar, Pargament & Mahoney 2003) find that those who are religious have better indices of mental health. These indices could have been possible as posited by Dein (2006) to include positive cognitive appraisals, increased social support, healthy lifestyles (diet, less alcohol and drugs) and supportive relationships with God. Social relationship in church found to be an explanation factor for good mental health indices. Ellison and George (1994) state that the influence of social ties in church could be a possible factor since people involve more in their faith; they tend to get more support compared to individuals who are less involved.

Additionally, Taylor and Chartters (1986) opined that assistance given to members at church could complement whatever support is provided at home and this in Asians and Hispanics, religious organizations is seen as a custom (Meadows, 1997). This finding could explain the reason for most mentally challenged to rather resort to religious faith in anticipation for their treatment as well as seeking supports which could not have been provided at home as a result of stigma and demean treatment of mentally ill (Fournier, 2011) especially in Ghana.

Place of Residence

According to WHO (2014), observation on Social Determinants of Mental health, and many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live. One's mental health is largely also shaped by the community in which one resides of which neighbourhood trust and safety, community based participation, violence/crime, attributes of the natural and built environment, neighbourhood deprivation exist (WHO, 2014).

Crisis in communities, especially civil wars as well as ethnic disputes affect individuals, communities as well as institutions which lead to breakdown of family, social networks and community bonds. In these conditions, the effect on social support is great since these institutions especially serve as a vital source of social support for people who may be in need of such social resources. Hoge (2004) found that conflict situation increases disorder prevalence among people within a conflict zone. Other violent acts in the area of gender based killings violent displacement by any other means for example, natural disasters such as flood, which displaces people and thereby affect livelihood could significantly affect people and lead to stress, which could affect one's mental health (WHO, 2005; Carballo, 2004). In Durkheim (1897), it showed that social disintegration of a community is associated with an increased rate of mental disorders in those communities. For example, the disintegration of community by high rates of lonely people, divorces, abandoned children, and lack of social support, violence, crime, drug and alcohol problems. This, Durkheim opined, was because of social resources, which significantly affect people in the area or community they find themselves.

Likewise, communities where people feel rejected, discriminated upon and given unequal opportunity could account for mental health problems (Gostin, 2001; WHO, 2005). For instance, restriction in civil liberties such as right to vote, to take part in public affairs to express one's opinion, freedom of association, assembly and movement can affect mental health (WHO, 2005). In addition, Sen (1999) found that gender inequalities in areas such as education, employment and civil liberties carry a cost such as depriving women of basic freedoms and violate their human rights, which negatively affects development outcomes for societies as a whole.

A study by Bell and Rubin, (2007) on 'Why Place Matters: Building a Movement for Healthy Communities' found that the social environment in which one find himself/herself contributes significantly to health. They found that people need strong social networks to thrive. For instance, in social support, literature, type of networks, which is an aspect of structural support (House et al., 1988), fosters a sense of belonging and affirms culture and community. Putnam (1995) opined that networks can have positive political impacts, including bringing more government services into a neighbourhood. In understanding community support, Bell and Rubin (2007) further illustrate that social capital plays a crucial role in the linkage with health. They found that there are two key types of social capital, which are bonding capital, and bridging capital (Bell & Rubin, 2007).

Bonding social capital deepens relationship within an immediate community whiles bridging social capital strengthens the links between one group and people and institutions in larger neighbourhood. It is evident that social capital can improve access to services for people with mental disorders and so shorten the duration of these disorders (Sartorius, 2003). Woolcock (1998) corroborated this by asserting that social scientists have investigated how higher social capital may protect individuals from social isolation which among other things creates social safety, lowers crime levels, improves schooling and education, enhances community life and improves work outcomes. This finding could mean that discrimination of a kind as well as ethnic and political tension could account for social deprivation in a community one finds him/herself which could lead to various consequences of unemployment, income inequalities, unfavourable duelling conditions of which mental health could be pervasive.

Culture and Ethnicity

Mental illness is seen as a taboo subject that attracts stigma in most African countries and communities which results in demeaning treatment of people with mental illness as well as affecting support (Fournir, 2011; WFMH, 2015). In Uganda, work done by Gordon (2013) showed that mental health illness culturally not accepted among the population. For instance, the term depression is not accepted.

According to Mak and Cheung (2008), stigma both public and self-stigma is so pervasive in African countries such as Nigeria and Ghana. An illustration of this by Arboleda-Flórez (2002) in his work, 'What Causes Stigma?' found that people mentioned fear, avoidance and anger for those who were observe to have mental illness. He concluded that the element of stigma of mental health attributed to lack of education, fear, religious reasoning and general prejudice. In Haiti for example, a range of factors explain illnesses based on cultural, religious and social beliefs (WHO, 2005).

Mental health issues in Haiti are supernatural forces and ascribed as consequences of spell or curse transmitted by a jealous person (WHO, 2010). Similarly, WHO found that mental illness is attribute to people who are attractive, intelligent and successful who failed to please spirits in Haiti (WHO, 2010). Other cultural practices lead to social support for the mentally ill. As stated by Desrosiers and St Fleurose (2002), Haitians' external attribution to causes of mental illness could help in recovery as people call upon their 'spirits-Iwa-s' to intervene on their behalf in healing process since mentally ill people may be seen as victims of powerful forces beyond their control who therefore receive support from their community (WHO, 2010).

Informal Caregiving for the Mentally Challenged

Informal caregiving is describe as an activity or a set of activities to assist physical needs (Swanson, Jensen, Specht, Johnson, Maas & Saylor, 1997). It is also assume to include a provision of more psychological support than those provided by doctors and nurses. Bowers (1987) found five categories of informal caregiving which he states are i) anticipatory, ii) preventative iii) supervisory, iv) instrumental and v) protective. Anticipatory care are behaviours or decisions that are based on guess possible needs of a care recipient. This is like an anticipated support. On caregiving needs, Corcoran (1994) sighted example of a caregiver, who posits that, he was able to guess his impaired wife's thoughts and thereby made it possible for him to know exactly what to do with her needs.

Preventive care furthermore is active monitoring to prevent physical injury or illness and mental deterioration (Bowers, 1987). Supervisory on the other hand is active direct monitoring of the care recipients during time of difficulties. Person with mental health condition is normally supervise, for example, whether they are in right cloth or check if the mentally ill does not cause any harm to herself or someone. Protective care deals with shielding the impaired spouse from consequences, which have not prevented. For instance, if a mentally ill husband's condition is deteriorating, the caregiver could protect the spouse's image by protecting him. Instrumental care is again a set of tasks that traditionally come to mind when caregiving is needed (Corcoran, 1994). Such caring services include dressing, meal preparation, bathing, grooming and others.

Burden/Constraints of Caregiving

Caregiving burden is multidimensional response to the negative appraisal and perceived strain, which results from taking care of person suffering from mental illness or other challenges. It affects the physical, psychological, economic, emotional and functional health of caregivers (Parks & Novielli, 2000; Etters, Goodall & Harrisson, 2008). Burden of care has negative consequences for parties and thus caregivers and patients as well as family members and the entirety of the healthcare system (Malhotra, 2016). Malhotra (2016), sighted burden like physical, emotional and economic status as key areas caregivers are adversely affected. These negative issues affecting the caregiver could affect care, which could lead to poor mistreatment or behaving violently to the patients, which can lead to patients relapse.

Caring for someone who is mentally ill can affect the dynamics of family, because it consumes significant amount of caregiver's time and energy (Malhotra, 2016). These services have increased as results of de-institutionalisation of psychiatric patients and trends towards community care (WHO, 2013; Magliano, McDaid, Kirkwood & Berzins, 2007). Caregiving entails both subjective and objective burden. Objective burden for instance relates to the practical problems experienced by relatives such as the disruption of family relationships, constrains in social leisure and work-related activities, which result in financial difficulties and negative impact on their own physical health (Malhotra, 2016). Subjective burden describes the psychological reactions that relate to experiences such as feeling of loss, sadness, anxiety and embarrassment in social situations, stress of coping with disturbing behaviours and frustrations caused by changing relationships (Ostman & Hansson, 2004).

Faden, Bebbington, Kuipers, (1987), observed that burden, as a concept is associated with that of social performance. Poor social performance of one member reciprocally affects the performance of other members of family who have to make up for the deficiencies that lead to burden on them. A study by Jenkins and Schumacher (1999), posited that the types and levels of family burden could correlate to contextualise factors including gender, ethnicity, diagnoses and living situations.

Impact of caregivers comes with two dimensions, as it is different for individual caregivers. Some caregivers experience a substantial negative impact whiles others are not affected, but rather; see a positive aspect of caregiving (Schofield, Bloch, Herrman, Murphy, Nankervis & Singh, 1998). For instance, Victorian Carers Program conducted a population-based study in which differences in well-being between caregivers as a group and non-caregivers exposed (Schofield et al., 1998). They found negative aspects of caregiving such as, life satisfaction, positive affect, and negative affect among caregivers. Australian Bureau of Statistics (1998) (ABS) found that 30 percent of caregivers who complained of their wellbeing had been affected by caregiving and they were found to be worried (Australian Bureau of Ststistics, 1998).

On the other hand, there has been positive findings of caregiving, which include giving pleasure to the care recipients, maintaining the dignity and maximising the potential of the care recipients, experiencing enhanced responsibilities and sharing mutual love and support (Nolan, Grant, & Keady, 1995; Lundh, 1999). From the positive aspect of caregiving could come from parents whose loved ones, especially children or husbands are in crisis and caring in this aspect will show demonstration of love and in anticipation that the care recipients might cope better and get well in future. This is infer to be reciprocal where the caregiver sees the process as reciprocating assistants he/she has previously received from the care recipients.

Support Seeking, Sources and Constraints

Table 2 presents types of social support seeking behaviours. These are direct and indirect strategies, which are verbal and nonverbal. According to Connor-Smith, Compas, Wadsworth, Thomsen, Saltzman (2000), anytime there are difficulties in people's lives, for instance sickness or other challenges, one way of coping is to seek social support. They maintain that seeking social support is an adaptive coping strategy. Don, Mickelson, and Barbee (2013) and others found that the manner in which support seekers, which are caregivers and mentally challenged approached support interactions affect the way that supporters responded. It asserted that support seekers can approach support providers directly or indirectly and this is verbally or non-verbally. Similarly, Armstrong and Kammrath, (2015) investigated how an amount of support sought can be broken into two component tactics which is; the number of supporters one seeks (breadth) and the amount one seeks from each supporter (depth). Gender and attachment differences in overall support seeking accounted for by the breadth rather than the depth of seeking.

Table 2:Types of Social Support Seeking Behaviours

	DIRECT	INDIRECT
VERBAL	Asking for help Giving details of the problem	hinting about the problem complaining
NON-VERBAL	Crying	Pouting Sighing Fidgeting

Source: Barbee and Cunningham, (1995)

Breadth was associated with increases in perceived support availability, whereas both breadth and depth were associated with increases in self-esteem.

Those who seek support directly as outlined in Table 2 do normally result in quality support than seeking indirect support (Collins & Feeney, 2000). Even though social support has established an effective for both mentally challenged and the caregivers, people find it burdensome to seek for a support as a result worrying about being a burden to others in terms of time resources and emotional energy. Support seeking also affected by the gradual weakening of the extended family system (Bongaarts, 2004) where the nuclear family is rather becoming the order of the day. This could pose serious limitation on both patients and caregivers. Other cultural factors also do impede support seeking. For instance, in Asian countries, Segal (1998) opined that seeking help from external sources is shameful and loathsome. Support seeking and receiving as well do depend on the nature of the relationship people have with their network (Taylor, Sherman, Kim, Jarcho, Takagi & Dunagan, 2004). Cultural psychology advocates belief that different norms in relationship as individuals are encouraged to promote and maintain their distinctiveness and act according to their own volitions in more independent cultures such as in East Asia (Markus & Kitayama, 1991).

Different forms of social support relate to a variety of physical and mental health outcomes (Ashida & Heaney, 2008). Older adults for instance, may receive emotional support from their loved ones and feel useful when they are involved in their lives. High emotional support for adult link with positive mental health. Others also get support from various social ties such as friends, children, family members, significant others and spouses (Zunzunegui, Béland, & Otero, 2001). Similarly, a study by Min and Wong, (2015) on sources of social support and community integration sampled 399 persons with mental illness from community-based mental health service agencies in South Korea. They found that family support and friendship support positively influenced all three aspects of community integration. In addition, they found that enough support from mental health professionals was associated with increased perceived accessibility to community resources but decreased involvement in community activities.

Summary

The chapter examined the concept of mental health in which everybody should be able to realise their dreams and cope with normal stressors of life. It also looked at common mental health disorders, which the study largely targets, and severe mental health illnesses. Social support is a coping resource, which complements pharmaceuticals in healing of the mentally ill patients. The study conceptualises social support in three dimensions that is structural, functional and social negativity or negative social support.

Access to support by the mentally ill and their caregivers is difficult because of stigma and discrimination. This study explores socio-demographic characteristics including culture and the environment from the literature as determinants of social support amounted to the mentally ill and care givers. For instance, one's gender status determine amount of social support and resources available when ill. Besides one's age has tremendous influence on availability of social support and as well as sources. As one grows, social network for instance reduces to close networks such as spouses.

Likewise, constraints of caregiving on the mentally challenged explored. It found that caregivers have both burden and reward in caring for their loved ones who are sick. Furthermore, caregiving similarly influences resource availability for the mentally challenged or could even worsen the condition for both parties. Finally, the issue of sources of support and strategies for seeking support explored. It found that sources of support from close friends and family is useful and preferred by the mentally challenged. Direct seeking of support too from caregivers lead to a substantial support compared to indirect support seeking.

Finally, from the review it is infer that a range of factors, most closely interconnected influence the kind of support for the mentally challenged and these factors shaped by the social, economic and physical environment.

CHAPTER FOUR

THEORETICAL LITERATURE ON SOCIAL SUPPORT

Introduction

This chapter reviews concepts relating to mental health and social support. Theories, conceptual frameworks related to social support also discussed, examined and linkages drawn. Finally, a framework that guides the work is adapted from a number of related studies.

Concept of Mental Health

The World Health Organization (2013 p.38) defined mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". World Bank and World Health Organisation (2016) said that mental health is an integral part of health and provision of social services. Analysing the definition of health, WHO (2005), illustrate further that mental health is more than the absence of mental illness and it is intimately connected with physical health and behaviour. It argued same that mental health is a foundation for wellbeing and helps individuals and communities to function and thrive (Feeney & Collins, 2014; WHO, 2005). Likewise, neither mental health nor physical health can exist alone, but rather they are interdependent. Helliwell, Layard and Sachs, (2013) asserted that mental health is a single most important determinant of individual happiness and the cause of unhappiness in people all over the world is because of mental health.

Concepts of Mental and Behavioural Disorders

Mental disorders include anxiety, depression, schizophrenia, and alcohol and drug dependency. Patten (1991) proclaimed that common mental disorders could result from stressful experiences but also occur in the absence of such experiences. According to WHO, (2014) stressful experiences do not always lead to mental disorders. Many people experience sub-threshold mental disorders, which mean poor mental health that does not reach the threshold for diagnosis as a mental disorder. Mental disorders and sub-threshold mental disorders affect a large proportion of populations (Murray,Vos, Lozano, Naghavi, Flaxman, Michaud, & Aboyans, 2012). The less commonly used term, mental illness, refers to depression and anxiety (also referred to as common mental disorders) as well as schizophrenia and bipolar disorder which is also referred to as severe mental illness (Joint Commissioning Panel for Mental Health, 2013).

According to the British Psychological Society and the Royal College of Psychiatrists (2011), assessing the severity of common mental health disorders is determine by three factors: symptom severity, duration of symptoms and associated functional impairment (for example, impairment of vocational, educational, social or other functioning). Mild generally refers to relatively few core symptoms (although sufficient to achieve a diagnosis), a limited duration and little impact on day-to-day functioning. Moderate refers to the presence of all core symptoms of the disorder plus several other related symptoms, duration beyond that required by minimum diagnostic criteria, and a clear impact on functioning. Severe refers to the presence of most or all symptoms of the disorder, often of long duration and with very marked impact on functioning (for example, an inability to participate in work-related activities and withdrawal from interpersonal activities).

Concept of Social Support

Studies have shown that surgery and pharmaceuticals are not the only effective procedures used to improve health, but also the natural human tendency to care for fellow humans in supporting them with social capital with respect to the reciprocal relationships. This manifests itself in networks in a form of social support proven to be potent in treatment of mental health problems (Lourel et al., 2013; Basic Needs, 2014). Social Support is like psychotherapy and an informal equivalence of psychotherapy (Barker & Pistrang, 2002).

Social support is a multi-dimensional (Hupcey, 1998; Loural et al., 2013) concept with different perspectives. According to Rodriguez and Cohen (1998), social support refers to material and psychological resources available to individuals through their interpersonal relationships. Cohen et al., (2000), also see social support as the process of inter-action in relationships that improves coping esteem, belonging, and competence through actual or perceived exchanges of physical or psychosocial resources. Thoits (2010) conceptualised social support as emotional, informational or practical assistance from significant others such as family members, friends or co-workers and that support actually may be received from others or simply perceived to be available when needed. Cobb (1976) also defined social support as information leading the subject to believe that he or she is cared for and loved, esteemed, and a member of a network of mutual obligations. Similarly, Feeney and Collins, (2014) used an integrative model of thriving through relationships in which social support is conceptualised as an interpersonal process. They also see it to function to promote thriving in two life contexts. Thus, experiences of adversity and opportunities for growth in absence of adversity (Feeney & Collins, 2014).

Sociological Tradition

Durkheim (1897) discovered that those with fewer social ties and smaller social networks were more likely to commit suicide than those with a greater number of social ties and larger social networks. Durkheim was interested in what holds society together when it is make up of people with specialised responsibilities. With the division of labour in society, Durkheim propounded a theory of mechanical solidarity and organic solidarity.

Mechanical solidarity tend to be small with a high degree of religious commitment, and oftentimes people have the same jobs and responsibilities. Societies characterised by organic solidarity, on the other hand, were more secular and individualistic due to the specialisation of their task, which was more complex with a higher division of labour. Durkheim argued that societies moved from mechanical to organic solidarity through the division of labour. As people began to migrate into the cities and physical density, mounted competition for resources began to grow. As in the case of any competition, some people won and kept their jobs whereas others lost and were force to specialise.

Consequently, the division of labour generated all sorts of interdependencies between people as well as key elements of organic solidarity like a weaker collective conscience (Durkhiem, 1897). Durkheim argued that societies characterised by organic solidarity generated social solidarity not through sameness, but through interdependencies. However, this form of solidarity is risky and can be abnormal and produce anomie therefore.

Anomie refers to a feeling of disconnection from the moral norms and rules of a society. Durkheim stated that under a state of anomie, there is not enough moral norms and rules to counteract the individualism associated with a complex division of labour. A society that celebrates individuals runs the risk of forgetting to tell individuals what they could and could not do.

Some studies connect the outcome of Durkheim theory, that significant losses of social ties among those whose loved ones have migrated seriously affected group social integration (Durkheim 1897; Hawton, Harriss, Hodder, Simkin, & Gunnell, 2001). A number of related works in this domain asserted that those who participated in their communities and larger societies were in better mental health (Cohen & Will, 1985; WHO, 2003a). In addition, Greaves and Farbus (2006) as a strategy of preventing mental health in old people came up with a strategy called 'The Upstream Healthy Living Centre' that was based in England. This approach was design to identify and engage older people in rural areas who might experience situations relating to isolation. The Centre uses mentors to deliver special programs, activities and support, to improve social networks and get people involved in creative activities. An evaluation of the programme indicated that participants benefitted from attending the centre, reporting improved psychological well-being and reduced depression (Greaves & Farbus, 2006).

Another instance on studies by Kawachi, Colditz, Ascherio, Rimm, Giovannucci, Stampfer and Willett, (1996), examined prospectively the relationships between social networks and total and cause specific mortality, as well as cardiovascular disease incidence. This was a four-year follow up study in an on-going cohort of men, for whom information on social networks collected at baseline. The main outcome measures were total mortality, further categorised into deaths from cardiovascular disease (stroke and coronary heart disease), total cancer, accidents/suicides, and all other causes; as well as stroke and coronary heart disease incidences. Nearly, (32,624) US male health professionals aged 42 to 77 years in 1988, were free of coronary heart diseases, strokes, and cancer at baseline.

It revealed that 511 deaths occurred during 122,911 person years of follow up. Compared with men with the highest level of social networks, socially isolated men (not married, fewer than six friends or relatives, no membership in church or community groups) were at increased risk for cardiovascular disease mortality (age adjusted relative risk, 1.90; 95 percent CI 1.07, 3.37). Deaths from accidents and suicides (age adjusted relative risk 2.22; was 95 percent CI 0.76, 6.47). Socially isolated men were also at increased risk of stroke incidence. It was conclude that social networks were associated with lower total mortality by reducing deaths from cardiovascular disease and accidents/suicides. Strong social networks were associated with reduced incidences of stroke, though not of coronary heart disease. However, social networks may assist in prolonging the survival of men with established coronary heart diseases.

Social Capital Theory

There is a linkage between the concept of social capital (Putnam, 1993) and mental health. Social capital refers to social life such as institutions and social trust that shape the quality and quantity of social interactions and facilitate collective action, coordination and mutual benefit. Berkman and Glass (2000) saw social capital to be a subset of theory of social cohesion while Hawe and Shiell (2000) concluded from work of a number of theorists that social capital is not one thing but rather has relational material, and political aspects and it may have positive or negative effects. It can also refer to both dense and loose networks. It also take on different forms depending upon whether one is concerned with the individual and his immediate group membership or interaction between social institutions (Hawe & Shiell, 2000). Sartorius (2003) linked social capital to mental health by asserting that trust, social support and social networks are important determinants of mental health of individuals. It also found that social capital could improve necessary services for people with mental disorders that could aid in shortening the duration of the condition.

Muntaner and Eaton (1998) likewise asserted that psychological, social and physical resources available in a person's environment influence individual challenges. People who are vulnerable for depression for instance may be suffering from a lack of good relationship, unemployment and low social status (Perry, 1996). Individuals in crisis, for example, patients and caregivers draw on assistance and support on availability of social capital networks. These networks are nuclear and extended families, religious institutions, political organisations (WHO, 2005). Cunny and Miller (1994) pointed out that when individuals are recovering, they turn to their immediate families for emotional recovery and this influence mental health status. Linking these to structural aspect of social support, Rose (2000), revealed in his survey of contribution of social capital networks in Russia, that social capital contributed to basic welfare such as income security, health and food consumption and that measures of social integration explained almost 10 percent of the variance in emotional health.

According to WHO (2005), social capital added another dimension to understanding of mental health and mental disorder. It reveals that social capital broadens the bio psychosocial determinants of mental disorders, which include genetics, neurobiology, psychological factors, and social environment. This finding brings an understanding of population mental health beyond the aggregation of individual health characteristics.

Social Support and Adaptation

Social support is a resource promoting adaptation to stressful situations. According to the proponent of the theory (Selye, 1975) general adaptation syndrome encompassed all non-specific changes that developed over time during continuous exposure to stressor attack (Selye, 1975). Apart from the biological perspectives on adaptation, it has also social dimension, which refers to the process of integration, and psychology in which adaptation is describe as conduct used to maintain a state of equilibrium between a subject and his or her environment. Lourel et al. (2013) posited that adaptation could occur through assistance provided in a form of social support. An example on this as adduced by Charyton, Elliot, Lu and Moore (2009) showed that people who suffer epilepsy do perceive a higher level of emotional support to have better health related quality of life than those who perceive that their emotional support is weak.

Huang, Sousa, Tsai, and Hwang (2008) examined the relationships among contextual factors, dimensions of social support, adaptations and psychiatric symptoms among mentally ill adults in hospitals in Southern Taiwan. Their findings suggest that individuals who were older, male, independent and had higher education, a shorter duration of mental illness and fewer psychiatric symptoms, had higher life skills. Three dimensions of social support (belonging, tangible and self-esteem) moderated the relationship between psychiatric symptoms and number of hospitalisations. They concluded that life skills and social support played important roles in the adaptation of Taiwanese adults with mental illness in the community as well as decreased their psychiatric symptoms and number of hospitalisations.

Attachment Theory

Storr (1991) opined about John Bowlby who proposed theories suggesting that the environment considering childhood played a critical role in the genesis of neurosis. It was postulate that the separation of infants from their mothers was unhealthy and could lead to loss and separation as key issues for psychotherapy. Bowlby (1980) proposed that there is universal human need to form close affectionate bonds (Fonagy, 1996). Bowlby (1980) contends that the attached figure most often, especially the mother creates a secure base from which an infant or toddler can explore and venture forth. Attachments are primary motivation systems. He posits that secure attachment provides an external ring of psychosocial protection that maintains the child's metabolism in a stable state similar to internal homeostasis of blood pressure and control (Bowlby, 1969). According to the theory, the intimate bonds created in childhood form a secure base for attachment in adulthood and provide prototypes for later social relations (Fonagy, 1996).

It is intimate that the attachment theory could inform support seeking and caregiving since it is a process that involves the attachment system and caregiving system (Bowlby 1982). It also gives clearance on the importance of support and care giving process. It was identify that the individual differences in attachment style may influence the nature and quality of supportive exchanges between intimate partners (Collins & Feeney, 2000). Bowlby (1982) intimated that attachment behaviours in childhood and infancy regulate by an innate tendency that functions to promote safety and survival by maintaining a child proximity to a fostering caretaker. Collins and Feeney (2000) stated that when a child is in trouble or sick, the attachment system will activate and the child will look for protection and comfort from the attachment figure that in most cases is the mother or father.

This attachment could form a basis of one's relationship with members of the family, which could be a fertile ground for support when one is in trouble for later life. As said by Berkman, Glass, Brissette and Seeman (2000), the strength of this theory depends on an individual's need for secure attachment for its own sake for the love and reliability it provides and for its own haven (Berkman, et al., 2000). Attachment at the primary level promotes a sense of security and self-esteem that provides the basis on which the individual will form lasting secure and living relationship in adult life. It is inferred from the theory that the child's ability to rely on the attachment figure as a safe haven at difficult moments is seen to be a key component of well-functioning attachment bonds and key predictor of healthy emotional developments (Collins & Feeney, 2000). This theory relate to various caregiving practices in our communities. It also relates to relationship building among the family members in supporting each other when one is in trouble. Again, the childhood experiences could be a fertile ground for supporting or seeking support from friend's family members in future.

Theory of Optimal Matching Hypothesis

The theory posits that stress protection occurs only when there is a match between the needs elicited by the stressful events and the functions of support perceived to be available (Cohen &Wills 1985; Cutrona & Russel, 1990). Social support is beneficial following specific kinds of stressors. For instance, having people to talk to about problems which is appraised or information support and having people who make you feel better about yourself could meet one's need. Cutrona and Russell (1990) review over 40 studies, which examined the associations between the specific components of social support and different aspects of stress, are particularly note-worthy. They found that about two-thirds of the studies reviewed supported the optimal matching model. For instance, uncontrollable events, emotional support plus the support function that matched with the specific domain (e.g., financial assistance for financial strain) predicted positive outcomes. For controllable events, however, they reported that instrumental support and esteem support were associated with positive outcomes. This theory shows that mentally challenged may need varied degrees of social support, and personal interaction with them could give the idea of the kind of support they need.

Conceptual Framework of Direct Effects of Social Support

This conceptual framework demonstrates effects of social support on health in which two concepts are used (Cassel, 1976; Cobb; 1976; Cohen & Wills, 1985).

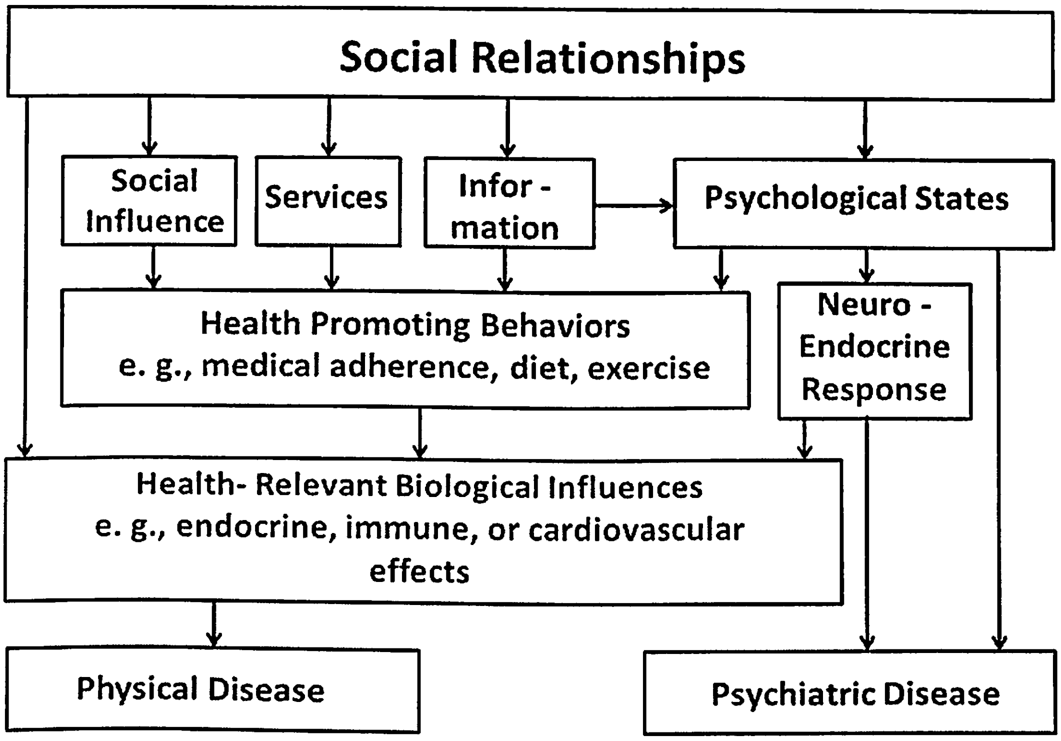

Figure 2: Direct Effect of Social Support

Source: Cohen, Gottlieb and Underwood (2000)

The first conceptual framework is direct effects of social support in which social support is having a beneficial effect on well-being independent of stress level as demonstrated in close relations (Lakey & Orehek, 2011). The direct-effect of social support consequently prefigures a causal model in which the independent variable for instance, socio-demographic variables – causes variations in the dependent – in this case, social support which then acts on mental health – notwithstanding the maintenance or control of all other variables. Social support appears to promote a general sentiment of well-being (Cassel, 1976) and helps to foster self-esteem (Lakey & Cassady, 1990). As an illustration, those who participate in social network are subject to social controls and peer pressures that influence normative health behaviours. For instance, their network could influence whether they exercise, eat or smoke. This integration provides positive affect, which leads to sense of control and belonging, self-worth which has been seen to have positive effect on mental health (Thoits, 2010; Uchino, 2004).

Strengths and Weaknesses of the Framework

If psychiatric diseases are often stigmatised in our society, then people seeking support will inhibit and this will affect social support (Fournier 2011) such that group integration could seriously affect. Therefore, the relationship could be bi-directional in which people with physical diseases or mentally challenged could suffer from getting social resources which could cause isolation and even worsen, the healing process. However, this could provide more social support if a network tie is strong and that of obligatory ties where family, friends and significant others see a member in need as their own problem.

From Figure 2, it could be inferred that the density of network could be explaining the reason why some mentally challenged are left to roam on the street whiles others are cared for by their spouses, families or significant others no matter the level of the condition. Although, Cassel demonstrates this direct effect of social support on mental health and other diseases, current thinking in population mental health points out those socio-demographic and social environments are major determinants of mental health (WHO, 2014). Moreover, this inferred from related work that socio-demographic determinants could shape determinants of social support for the mentally challenged in Ghana.

On the other hand, social integration could be misinterpreted, which could develop negative social behaviours. This could be harmful to especially some groups of people. Peers who want to conform to group norms in alcoholism and smoking could develop mental diseases that will come as negative effect of social integration. Uchino (2004) corroborated this by explaining that social ties can also reinforce social pressures to engage in negative health behaviours. For instance, alcoholism that in itself can lead to depression and others. This corroborate what Thoits (2011) posited that group members could model risky or preventive health behaviours which made social influence through comparison processes. This may have damaging or protective consequences for health, depending on the reference groups that individuals view as salient and the predominant health beliefs and behaviours within those groups.

Conceptual Framework of Indirect Effect of Social Support on Health

The second conceptual framework is the indirect effects or stress buffers which the effect of the independent variable on the dependent variable mediated by a third variable referred to as a mediating variable. Social support appears to link to physical and psychiatric illnesses through multiple "mediating" variables (socio demographic characteristics, social influence, access to services and information) that are associated with biological parameters and neuro-endocrine responses. Cobb (1976) emphasised the effect of social support as a stress buffer and showed in studies that the existence and quality or inversely absence of social relationships play a role in wellbeing throughout lifetimes.

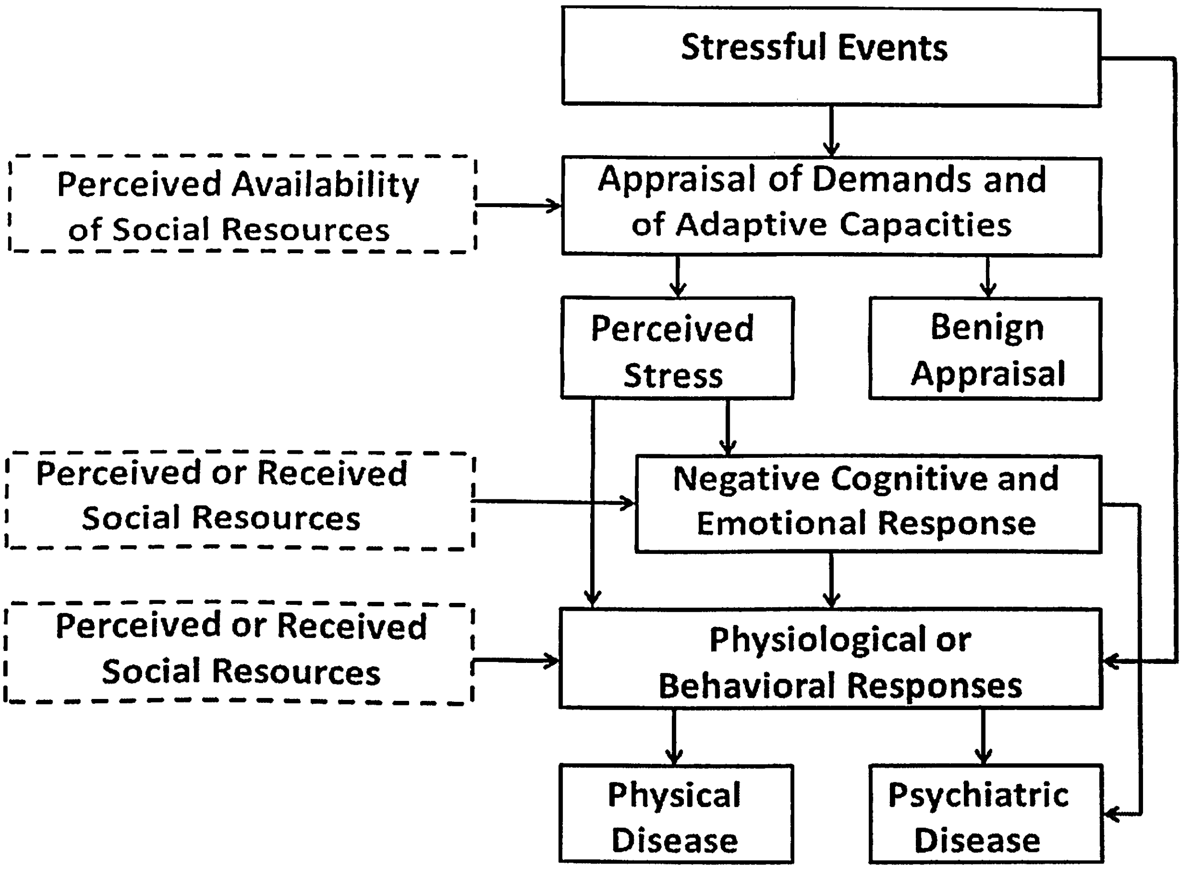

Figure 3: Indirect Effect of Social Support.

Source: Cohen, Gottlieb and Underwood, (2000).

Cobb (1976) concluded that adequate social support helps protect individuals from a variety of physical and psychological disorders during crisis likely through the adoption of coping and adaption strategies. He concluded that individuals facing crisis without support from significant others, friends are more likely, about ten times as likely to experience depression (Cobb, 1976). A study by Cohen (1991) corroborated this by asserting that over 40 studies confirmed buffering or protective effect of social support on negative consequences of support.

Strength and Weakneseses of the Framework

Some short falls of the model in the current and present study are that, psychiatric diseases or physical diseases could also produce stressful situations. Therefore, there should be bidirectional relationship between physical diseases, psychiatric diseases as well as other biological variables that determine a stressful condition. The environment as well as socio-demographic characteristics of an area or a person could also lead to stressful events, which are explain to be the process that occurs due to an imbalance between demands from an organism's environment (Lazarus, 1966). For a situation to trigger a stress reaction, it be a harm, loss, threat or challenge (Lazarus & Folkman, 1984). These indicators for stressful events, which could result in a mental status of individuals, are largely determine by the socio-demographics, environmental and biological events.

World Health Organisation (2014) demonstrated evidence that socio-demographic characteristics relate to the risk of mental illnesses, which in the developed and developing world is associated with indicators for instance, poverty, including low levels of education, and in some studies, with poor housing and low income. The greater vulnerability of disadvantaged people in each community to mental illnesses explained by such factors as the experience of insecurity and hopelessness, rapid social change, and the risks of violence and physical ill health (WHO, 2014).

A Conceptual Framework on Negative and Positive Social Support

Close relatives do involve in conflict, miscommunication and other negative process. It is observe that when two individuals are involved in relationship, their agendas (Brooks & Dunkel, 2011) will not always align. As they depend on each other, there is also potential for conflict, this could be partners, children, parents and friends. This resonate with social exchange theory where in a reciprocal relationship; exchange of gifts plays a key role in stress development. For example, in a relation where one always receives, there could be a burden, which could cause social ties to disintegrate and make recipients more vulnerable to stressors.

Cohen (2004) contended that the concept of negative interactions applies to all negative aspects of social environment. This is happening in varied forms such as spread of contagious diseases, isolation, interpersonal conflict, exploitation, transmission of stress as well as miss-guided attempt to help. Lourel et al. (2013), posited that negative social relationships could be characterised in two ways that is inappropriate support, forms of stigmatisation associated with stress and the absence or inadequate social relationship. Helgeson, Novak, Lepore and Eton, (2004) found that the negative aspect of social relationships may be more predictive of health than positive social interactions.

Lourel et al. (2013) posited that isolation and interpersonal conflict could be a force explaining negative interactions. Isolation is explain by Cohen et al. (2000), to be responsible for increasing negative effects and decreasing feelings of control and self-esteem that is seen as a stressor. Again, interpersonal conflicts lead to unhealthy behaviours associated with harmful environment since these affected by endocrine changes (Cohen et al., 2000). According to Granovetter (1973), strength of a tie is a (probably linear) combination of amount of time, the emotional intensity, the intimacy (mutual confounding), and the reciprocal services which characterised the tie (Granovetter, 1973). By implication if these characteristics are not in a tie, the tie could not be strong and whatever support provided could be weak and negative.

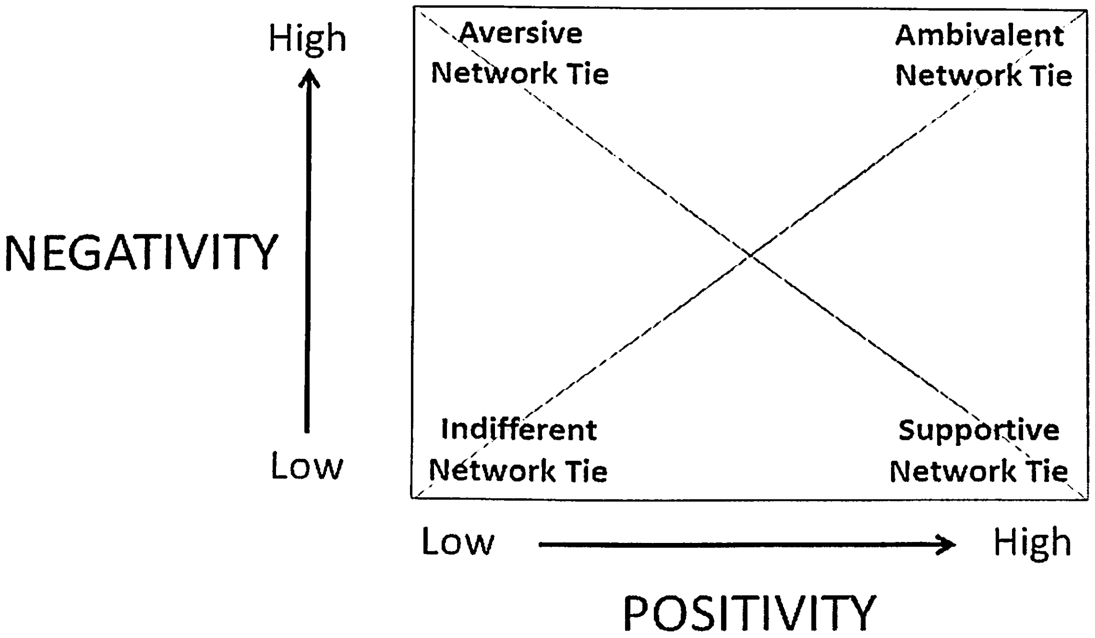

Figure 4: General Conceptual Framework Incorporating the Positive and Negative Aspect of Social Support for Health.

Source: Uchino, Holt-Lunstad, Uno & Flinders (2001)

Uchino et al. (2001) put forward a conceptual framework (Figure 4) that explains the positive and negative aspects of social relationships. It found that one's social network could classify as a source of positivity, negativity or a source of both positivity and negativity (Campo, Uchino, Holt-Lunstad, Vaughn, Reblin & Smith, 2009). The high positivity/low negativity side explained social network ties that are sources of social support for instance, supportive friends or families. This is link to strong or weak dimensions. This is because strong ties provide support while weak ties may not be concerned. However, there were studies that found that there were strength in weak ties (Granovetter, 1973). The corner with low positivity/high negativity is denoting network ties that are of negativity or aversive ties; an example is unreasonable work supervisor. This could also happen in groups where there are unnecessary controls which members find difficult to conform. In addition, the low positivity/low negativity corner is social indifference, which could represent a network tie that is characterised by low frequency or depth or less importance. For example, casual co-workers. This could also happen when networks are not obligatory or strong in a way that responsibility in providing a support is as not binding on members. The high positivity/high negativity corner labelled ambivalent network. Such ties are network members that are a source of both positivity and negativity, for example, loving but argumentative in-law. It found that some networks frown upon certain behaviours from group member is especially smoking or drinking.

This control according to Thoits (2011) is a source of distress but in later life could be as a good preventive measure to improve health. From the figure, Uchino et al., (2001) contended that high negativity includes both socially aversive ties and socially ambivalent ties. Again, high positivity included both socially supportive and socially ambivalent ties. This framework is influence by culture that will influence the way individuals behave in a group. Similarly, with socio-demographic characteristics for example, gender could also influenced how people perceived social support since perception of support attributed to both negative and positive outcomes. Social support for various network ties could also be influenced by place and social resources or capital within a geographical set up based on norms hence the environment could play a very vital role in determining how these four-network ties operate to bring about either negative outcomes or positive outcomes.

Specific Influence of the Frameworks on Mental Health

The direct and indirect effect model (Cobb, 1976; Cassel, 1976; Cohen & Wills, 1985) stress through which social support affects both physical health and mental health. This is studied and new dimensions and thoughts have been added to understand various mechanism in which social support influence health (Thoits, 2011; Uchino, 2004; Feeney & Collins, 2014; Cruwys, Haslam, Dingle, Halam & Jetten, 2014; WHO, 2014). According to Thoits (2011), pathways through which networks and social ties affect physical and psychological wellbeing. Social influence identified as one of the ways social support have effect on health. Berkman et al., (2000), asserted that social structure of network itself is responsible for determining individual behaviour through various supports or resources individual needs. Likewise, social control (Uchino, 2004; Umberson & Montez, 2010) conforming to a group where individuals mimic group behaviour could be a significant contribution to health. This is perceive as both positive and negative effect.

Seeking preventive care could also influence people. This is because this group could be a source of risk or prevent health behaviours. as contended in a convoy model in which the individual is seen in a life course perspective as travelling though surrounded by members of his/her cohort who provide support to one another reciprocally over time (Antonucci & Akiyama, 1987). A study of depression by Cruwys et al., (2014) for instance, found that social identities provide meaning to life, encourage the provision and receipt of social support, facilitate social influence, and engender a sense of belongingness in a group, which in effect contributes to the power of social identity to protect against depression.

Model of mood dynamics is used to explain the effect of social support on health (Abro, Klein & Tabatabaei, 2015). This model explained mood level appraisal and coping skills of a person. How levels of these states affect the external behaviour in a form of selection of situations over a period. Perception of support especially actual support and perceive support in the stress buffering hypothesis (Figure 3) is corroborated in a number of studies to contribute significantly in coping which help distressed people. For example, the mentally challenged manage and engage in activities that lead to speeding of their healing. For instance, perceived availability of social support in a stressful event may lead to a more benign appraisal of situations, which will prevent a cascade of ensuring negative emotional and behavioural responses.

Some of the key pointers emanating from social support which affect health and for that matter mental health are behavioural guidance, self-esteem, sense of control, belonging and companionship, emotional sustenance, concept of thriving, isolation which is negative support and others (Thoits, 2011; Uchino, 2004). Behavioural guidance also occurs in a group where societies comment on behaviours that could lead to psychological problems in an individual. For instance, family, and doctors may comment on smoking, alcoholism or use of tobacco, which may damage individual's health thereby, lead to influencing the group behaviour positively. This is in studies to influence reactivation of self-esteem and self-identity that control depression (Thoits, 2011; Cruwys et al., 2014). Sense of belonging also emanates from social identity that contributes to psychological resources. Evidence suggests that merely thinking about one's group membership has the capacity to reinforce a sense that one has a social place in the world that protects against physical and psychological wellbeing.

Conceptual framework for the study

Both empirical and theoretical frameworks inform the conceptual framework (Figure 5) for the study. the framework explains that mental health outcome whether positive mental health or mental illness could broadly be shaped by a number of factors either in a larger community or even in a family, work, group or at an interpersonal level. This, (WHO, 2014) and others referred to as social, economic and physical environment factors in which individual, socio-demographic and economic characteristics affect mental health.

Likewise, the environment determined by international, local laws as well as policies that shape largely how societies are pattern and therefore resources those individuals can depend on for survival or thriving. The nature of either a macro or micro society shaped by especially, values and norms as well as culture, which determine availability of resources for people in various groups and families. A society that discriminates and stigmatises less privileged people could lead to an equal distribution of resources, which may put people in vulnerable situations thereby producing stressors. Characteristics such as change in the environment and type of family orientation could greatly affect resources through caregiving processes in the family. Families that are orientated towards nuclear family will not have any obligation towards extended family as well as availability of resources such as social capital. Once again, a conflict society could also produce stressors that deny people an equal access to resources, which could lead to anxiety and depression.

The environment depending on culture, norms and individual's self-concept and self-efficacy could also produce stressors that may be sickness, death, hardships, unemployment etc. However, available and appropriate support from friends, groups and families could help individuals cope and shield them against any challenges or stress that might come up at various supportive actions that take place in the environment and happen at group or individual levels. The type of network such as supportive or aversive also shaped by culture and one's personality that could affect people positively or negatively. These various supports are appraise variously, which activate one's neuro-endocrine system which impact on mental health either positively or negatively. For example, one can belong to a group but could feel lonely which could change one's mood leading to depression.

When people have needed social support through networks, it leads to happiness that impact positively on both mental and physical health, thereby leading to overall growth in the specific area that these social resources is available. It has also been realised that there is a combination of social, biological and physical environment operating in an interconnected manner to affect health of which both physical and mental health are affected.

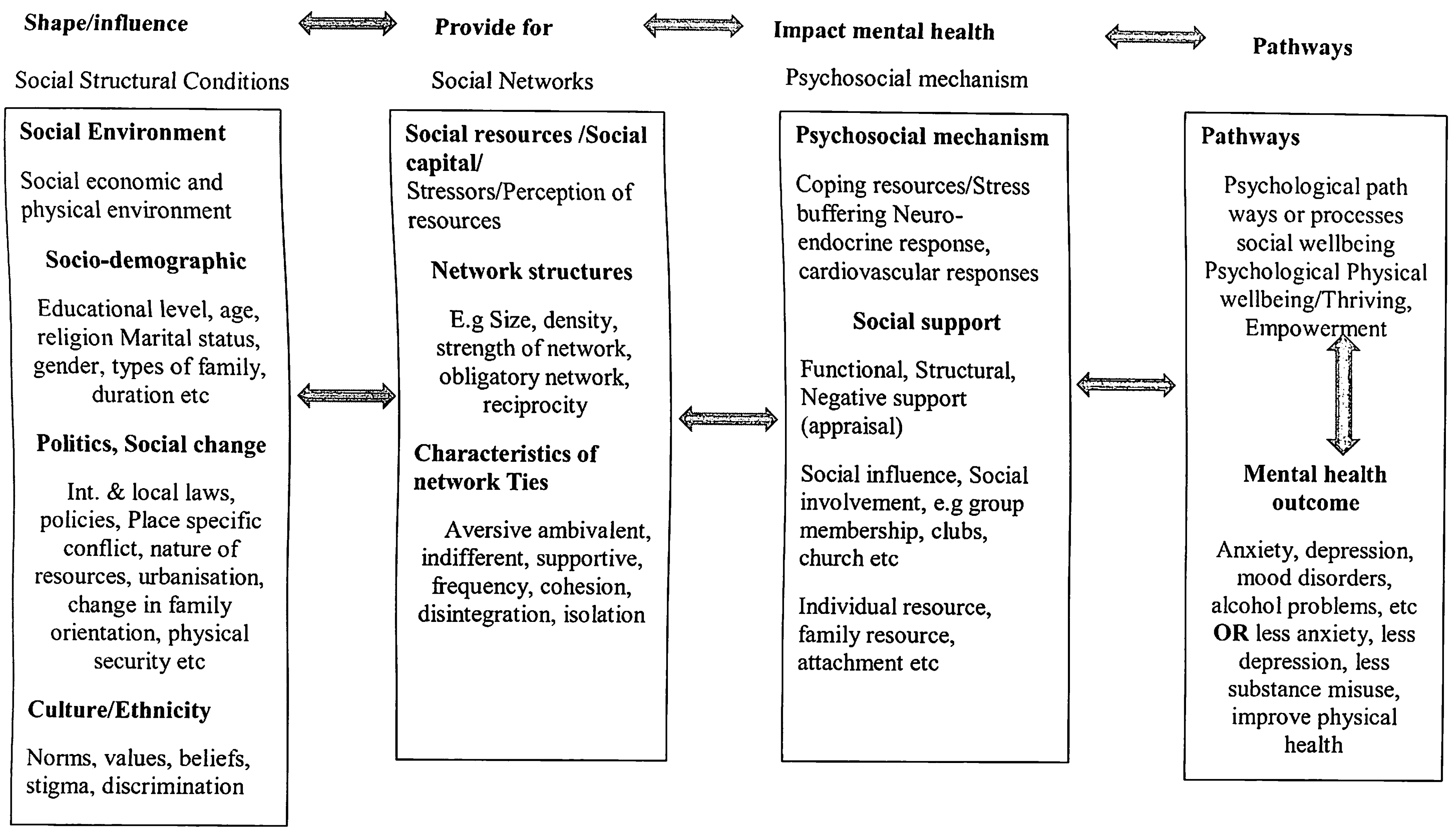

Figure 5: Conceptual Framework for the Study

Source: Authours Compilation from Different Sources.

Summary

The chapter reviews a number of theories that explain social support as a cushioning resource and various mechanisms in which social support affects both physical and mental health. It also explains networks that could be strong which could provide adequate caregiving for example attachment theory. Another key lesson from the chapter is that both tangible and perceived support provides a level of coping for the mentally challenged. Critically, it is also assume that the three types of support could take place in one's personal life or in a group at the same time. That, before one gets a support of whatever kind, one must belong to a group or have an interpersonal relationship with the family. Whatever type of support one is given occurs in an interwoven relationship where structural support plays a role of networks which in turn provides either emotional, companionship, tangible support which is functional and one's appraisal of these supports could lead to negative support based on culture, gender, and personality types or even problems with group conformity. The same support that could make one cope could as well make one feel isolated if not appraised well.

Finally, support cannot happen in a vacuum, it needs social resources and the make-ups in the environment. This then shape various structures and actors that lead to various mechanisms for mental health or common mental disorders.

CHAPTER FIVE

METHODOLOGY

Introduction

This chapter focused on the methodology employed in the study to address the objectives. In doing so, it concentrated on the research philosophy guiding the work that informed data collection process as well as analysis. Besides, it provided a description of the research design employed and ethical considerations for the study. It also described the study areas and the characteristics in these areas for the study.

Study Setting and Profile of the Institutions

The setting comprised of three health facilities. The facilities were the Accra Psychiatric hospital, the Pantang hospital and Ankaful hospital in the Central region.

The Accra Psychiatric hospital specialised in consultations, both inpatient and outpatient services, limited counselling and therapy, as well as clinical training for doctors, psychologists, and psychiatric nurses were available to attend to patients. Other services such as lab services, teaching and research, occupational therapy services, Alcoholic Anonymous (AA) meetings, Narcotics Anonymous (NA) meetings were all in place. In terms of charges for accessing services, the facility gave discount to particularly low earners. Schizophrenia, Depression, Bipolar disorder, Seizure disorder, Alcohol & Substance abuse, acute psychotic disorder, Dementia Anxiety disorders, Mental retardation and

Migraine were top ten reported cases for outpatients at the Accra psychiatric hospital. The facility headed by Hospital Director, Head of Administration, Head of Nursing, Head of Accounts, Head of Pharmacy and Clinical Coordinator.

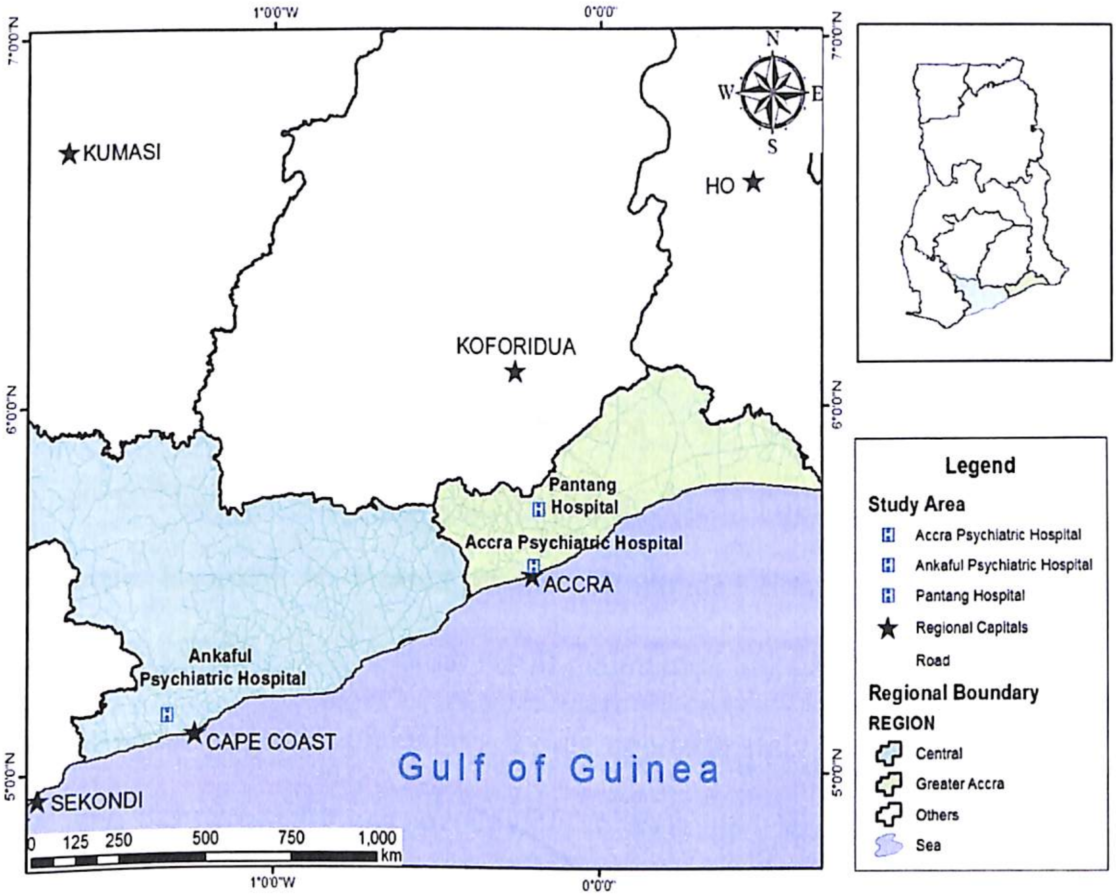

Figure 6: Study Areas in Regional and National Context

Source: Department of Geography and Regional Planning (2018)

The Pantang hospital was the largest among the three psychiatric hospitals selected for the study. It was established in the rural Pantang village in the Greater Accra Region in 1975 to reduce the congestion at the Accra Psychiatric hospital. Even though the intent of Government of Ghana as at the time, for establishing the facility was to provide psychiatric services, increased demand for general health, service had pushed it to provide for people in the immediate surrounding of the facility general care services. It was planned to be a regional psychiatric hospital with a 500-bed capacity, but in addition to the original psychiatric services, the hospital provided services in primary health care, reproductive and child health services, HIV counselling, screening, and ART (anti-retroviral treatment) services.The psychiatric services were depending on the request of patients. A Psychiatric Hospital Director, DDNS Head of Nursing and Head of Administration were the managements of the institution.

Secondly, Ankaful psychiatric hospital provided specialist psychiatric services as well as general outpatient services to the public. The facility accepted patients from all the regions of the country as well as neighbouring states. Foreign cases from La Cote D' Ivoire, Burkina Faso, Togo and Benin. Ankaful Psychiatric Hospital was also established in 1965. Politically, the Ankaful Psychiatric Hospital is located in the Komenda, Edina, Eguafo, Abrem Municipal Assembly, even though it still maintained links and communications with the Cape Coast Municipality. It was approximately 12.5km from Cape Coast and 6km from Elmina, occupying an estimated land area of about 1.5 square km. It was precisely located at the village called Ankaful where it derived its name; it shared boundaries with Ankaful Leprosy/ General Hospital to the South and the Ankaful Prisons in the west and north with Tsikweikrom village. The Hospital had eleven (11) wards but only seven (7) were operational.

Being one of the leading Psychiatric hospitals in the country and the sub-region, it provided 24/7 mental health services to everyone with various form of mental illness. In addition to mental health services, the hospital provided General Medical Services. The Family Health and Reproductive Care Unit (FHRCU) run 24/7 services and provided the following services; Antenatal Care, Postnatal care, Deliveries, Family planning, Child welfare clinics and Adolescent health clinic. It provided drug and alcohol counselling, HIV and

AIDS counselling, adherence counselling, suicide counselling, psychotherapy, anger management, stress management and family therapy. This clinic was gear towards providing holistic care for people with epilepsy. Every Tuesday, clients undergo counselling, education on condition and medication and the importance of reporting for review and prevention of relapse. Critical conditions were detained and managed.

Research Philosophy

The field was about social sciences, explanations, methods, empirical arguments, theories, hypothesis and so forth. These fields actually occurred in the social sciences literature in the past and present. The field similarly was also epistemic. It was concerned with the idea that scientific theories is put forward as true or probable and were justified on rational grounds for instance, empirical and theoretical.

The study employed positivist and interpretive approach because of the mixed method. Positivist approach by Sarantakos (2005) was the belief in the universal laws and insisted on objectivity and neutrality. Positivists followed the natural science that required the application of tested theories and hypothesis to the study. From August Comte's view, the traits of this was the quest for objectivity and distance between researcher and those studied. This also involved numerical measurement, statistical analysis and search for cause and effects that results in objective and factual knowledge of which quantitative method employed. Livesey (2006) posited that identifying facts about how and why people behave as they do and eventually making connections between different facts to produce theories that explained behaviour resulted in reliability. Methods such as questionnaires, comparative and observational studies employed to give a higher level of reliability in the positivist approach to the study of phenomena.

Interpretive approach on the other hand, according to Given, Winkler and Willson (2014), derived it roots from philosophical and human sciences, particularly those that relate to anthropology. The methodology involved the way in which human beings made sense of their subjective reality and make meaning out of it. Livesey (2006) realised that interpretive idea was based on three principles, consciousness which involved the individual knowledge of themselves as unique beings and their relationship with others and therefore made deliberate action which involved choices about how to behave in different situations or context (Livesey, 2006).

It also related to unpredictable behaviour that could not be studied in quantitative manner. It employed subjectivity, which was that society does not exist in an objective, observable form. Rather, it was experience subjectively as it gave meaning, by the way people behave and create and recreate a sense of the social system on the daily basis. It stated that when studying behaviour, the best approach was to describe and explained it from the point of view of those involved. The concept further stressed that facts about behavioural changes were context-bound because they do not apply to all situations.The positivist and interpretvist approach in the study of social support is observed by Rodriguez and Cohen (1998) to be multi-dimensional as they were able to offer explanations to the changes in characteristics and functional relationship of phenomena.

Research Design

Burns and Grove (2003), referred to research design as a blue print for conducting a study. A research design helped a researcher to have maximum control over factors that may interfere with the validity of his findings. Others for instance, Kothari (2004), saw research design to be the overall strategy that one could employed to integrate the different components of the study in a coherent and logical manner. The reason was to ensure that one effectively solved the research problem. It could also be a road map to obtain answers to research questions.

This study therefore used mixed-method approach. It was exploratory because it employed both qualitative and quantitative methods to the socially related issues that have effects on mental health (Tew, Gould, Abankwa, Barnes, Beresford, Carr, 2006). The study dealing with functional aspects of social support, for instance, employed in-depth interview to guide the understanding of various forms of support. Additionally, this form of design recognised intangible factors, such as social norms, socioeconomic status, gender roles, ethnicity, and religion, whose role in the research was to act as independent variable on the social support variables. As this was a mix-method, qualitative research could help to interpret and better understand the complex reality of a given situation and the implications of quantitative data.

The study employed an aspect of cross-section because it enabled the researcher to collect information from diverse socio-demographic backgrounds. Certain characteristics, such as people having mental health problems which included both men and women of certain age groups, perceptions and attitudes (structural aspect of social support common mental health problems such as anxiety, depression, stress and demographic variables) was collected through the use of questionnaires. Similarly, cross-sectional study was the simplest range of descriptive or observational epidemiology conducted on representative samples of a population (Babbie, 2009). It described the relationship between diseases (or other health-related states) and other factors of interest as they exist in a specified population at a particular time. It is done on representative samples of the population for generalizations from the findings to have validity (Babbie, 2009).

The study used different data sources as well as multiple stake holders which, enriched the outcome of the study and according to Thurmond, (2001) this method increased confidence in research data, creating innovative ways of understanding of the phenomenon that revealed unique findings as well as integrating theories. In addition, this form of mix-method and data usage provided a clearer understanding of the problem (Denzin, 1978; Thurmond, 2001). From objective point of view, the use of multiple methods may be justified as a means of validating to make the findings well-founded and convincing whiles subjectivist perspectives was seen as a way of exploring the data creating different form of and increasing both external and internal validity which could add empirical support (Denzin, 1978). Validity is a judgment based on various types of evidence. This included the measure's reliability, whether it covered the construct of interest, and whether the scores it produced, were correlated with other variables they were expected to be correlated with.

Data Sources

The study employed the two main types of data that was, primary and secondary data for the study. Primary data was the data collected by the researcher themselves using for instance, interview, questionnaire, focus group discussions and In-depth Interview Guide. For instance, the other dependent variable (mental disorders or diseases) for this study collected through hospital records of various forms of mental disorders with patients' admission registers to get these records of diagnosis of patients.

Secondary data on the other hand was the type of data, which came from other studies by other institutions or organizations if data collection had completed (Kwek & Kogut, 2015). Even though there were some short falls in the used of secondary data, Monette, Dejoong and Sulliva, (2002) believed that secondary data provided quantifiable information on health. Similarly, it can also be treated as if they were data the researcher had collected (Monette et al., 2002).

Study Population

The target population included all in-patients and outpatients who were 20 years and above in the three selected facilities. Those who regularly visit the facility for a review with their caregivers were diagnose to have common mental health disorders in the three psychiatric hospitals of Ghana (Accra, Pantang and Ankaful Psychiatric hospitals).

Table 3: Participants for the Study

In-patients	Out-patient	Caregivers	Facility personnel
409	23	10	10
904	37,396		

Source: Fieldwork (2017)

Sampling Procedure

Sample Size Determination

The target population (Table 3) at the three facilities for in-patients as at June 2016 was 904. These were patients diagnosed to have mental health problems (Records department, Pantang, Accra and Ankaful psychiatric hospitals, June 2016). Patients' admission registers and records used to identify in-patients for the study. The study employed census sampling to illicit responses from all the 409 in-patients. This figure, 409 represented the actual number of patients whose conditions had improved (lucid interval), and were willing for the interview hence, complete enumeration of the patients.

Regarding the qualitative sample, the target population at the three facilities for outpatients were 37,396 (Table 3). Twenty-three 23 outpatients out of 30 were purposively selected from the three hospitals for the study. Twenty-three outpatients were ready and were in sound mind and were on maintenance drugs and whose judgement was sound to be interviewed. Griffin and Hauser (1993) suggest a sample size of between 20 and 30 for qualitative studies if participants were homogenous as in the case of mental health patients in the three facilities. The other group targeted were key informants such as facility personnel and caregivers. The actual number interviewed on caregiving experiences as well as constraints was (10). Purposive sampling was employ to identify facility personnel at the three facilities. Details of respondents included Nine (9) personnel from the three (3) facilities and one (1) mental health coordinator at the Mental Health Authority, making a total of ten (10). These personnel from the health facilities were facility Director Psychiatrics, Nurse Manager and Deputy Chief Health Service Administrator. Qualitative data according to Patton (1990) was concerned about in-depth information about the phenomenon under investigation of which sample size should not be of a problem.

Methods of Data Collection

Two main methods were employed in the data collection. These were by the use of structured interviews and in-depth interviews. The actual data collection started on March 17, 2017 and ended in July 2017 at the three facilities. All interviews were completed at the premises of the hospitals. Two each of the research assistants (Psychiatric Nurses) were at the facility for data collection using structured interview and conducted face-to-face in-depth interviews.

Data Collection Instruments

Two main instruments used to collect both qualitative and quantitative data. These instruments were forms of structured interview questionnaire and In-depth Interview Guide. With the interview questionnaire, four main tools used for data collection and the researchers depended on ICD-10 for various diagnoses in the hospital. There were also screener questions as outlined in the exclusion and inclusion criteria.

In-depth Interview Guide for Facility Personnel

In-depth Interview Guide for the facility personnel contained thirteen sections. The first two sections entailed identification and demographic data, which was detail with date, place, and time of the interview as well as the language used during the interview, were in English. Other sections had issues on care and services at the respective facilities, standard of treatment, psychosocial rehabilitation, rights of persons with mental challenge and challenges in providing care for both outpatients and in-patients. Other critical issues that the study considered were; conditions of the psychiatric hospitals, access to information by patients as well as their caregivers, levels of social support for patients, insurance scheme for treatment of physical diseases and issues on culture and gender.

In-depth Interview Guide for Caregivers

The In-depth Interview Guide for caregivers was employed to explore the burden of care in other words constraints that caregivers faced in supporting the mentally challenge. It entailed three sections. Section 1 was on identification data which indicated the time and place of the interview. It also indicated biographic data of caregivers in terms of age, gender, marital status and ethnic background. Section two explored constraints on the caregivers, issues of discomfort and caregiver's health as results of the situation they find themselves. Section 3 was on support seeking by caregivers for their patients. How patients behave when they need support and what strategies caregivers employed to get the needed support for their patients especially drugs that were needed to calm patients who were aggressive.

In-depth Interview Guide for Out-patients

The outpatients at the three facilities were interview on largely the qualitative aspect of support, which was functional social support (House, 1981). This entailed actual and perceived support. Section one entailed identification data and issues on socio-demographic data. Section 2 was on perceived emotional support whiles section three involved perceived instrumental support, which was an anticipation that tangible support might come when needed e.g. food, money. Section four asked patients on actual support received from caregivers, and friends.

Structured Questionnaires for In-patients

Instruments for quantitative data were demographic questionnaire schedule that formed part (A) of the entire instruments for the in-patients. This demographic data had linkage with social determinants of population mental health (WHO, 2014). It contained variables such as age, gender, religion, ethnicity and type of family system of the patients. Some of these variables were administered in a form of checklist. Others were marital status, educational level, income level, employment level and so forth. These form the main basis of the analysis as the main independent variables.

Social Network Index (SNI) (Cohen, 1991; Cohen, Doyle, Skoner, Rabin, & Gwaltnery, 1997) was adapted and forms part (B). A widely used instrument to measure structural social support. This was concerned about how many people patients talk to on a regular basis including family, friends, workmates, and neighbours even in their condition. It mainly assessed participation in 12 types of social relationships. It also took into account the existence and quantity of social relationships indicating how those relationships were pattern and organised (Thoits, 2011). Social integration was assess by how diverse one's relationship was as well as participation. This included spouse, close family member, friend, neighbour and social and religious group member. More relationship of a member shows their level of social integration. Other measures include (Stohl, 1995) network density which described how interconnected the members of the social network were with each other. Individuals may have a larger network but may not interact which will result in less dense social network (Mattson & Hall, 2011). Where there was a denser network, there was more potential for support which was explained to mean individuals working together to support members in need. This could also mean availability of social capital to an individual who is mentally challenged.

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988) forms part 'C'. It was about a potential support for patients or an idea that support might come from a family member, a close friend and significant other. It described both the source, perceived, and received support that compared to the qualitative findings. It was use as one of the dependent variables.

In addition, Social Relationship Index (Uchino, Holt-Lunstad, Uno, & Flinders, 2001) formed part (D) and was also employ to measure negative support in a form of checklist. It was concerned about various forms of support given to an individual being negative. For instance, criticism, disappointment from friends, which could be a potential ground for psychological problems in either patients or normal people. In the mental health literature, social negativity was often a stronger predictor of indices like distress, depressive symptoms, and satisfaction with life (Rook, 2001). However, it was use as one of dependent variables.

Instrument for Diagnosing Patients across the Facilities

Patients at the three facilities were normally diagnosed using International Classification of Diseases (ICD-10 Version: 2010), Chapter 5, Mental and behavioural disorders (F00 – F99) by psychiatrics and nurses. The instrument groups mental disorders into categories and subcategories and assigns each disorder a code number (F00-F99). It helped systemize and standardised diagnosis, speeds up the digitalization of record, and simplified comparisons between years, hospitals and countries. For instance, a patient whose diagnosis were within a code of (F10–F19) indicated mental and behavioural disorders due to use of psychoactive substances (alcohol-use and substance use syndromes, including harmful use, dependence, and withdrawal Table 4). These records (Table 4) were used as a measure in selecting the patients. The study focused on Common Mental Disorders (CMD) and sub-threshold mental and behavioural disorders which affect a large proportion of the population (Murray, et al., 2012) because it is observed that worldwide, depression and anxiety disorders account for up to a fifth of all disabilities.

Pre-Test of Instruments

Pre-test of all the instruments took place in Ankaful rehabilitation Facility. This facility had the same attribute of the patients in the three hospitals of Ghana. Social Relation Index was detected to include many measures which was quite confusing and so the instrument was reviewed to include only parents, significant others and the family. The pre-test took place during the whole of February 2017. For the first time, we came across a concept called 'lucid interval'. Thus, where patients were in touch with reality before you could collect data from them.

Table 4: WHO Classifications of Mental and Behavioural Disorders

1. (F00–F09) Organic, including symptomatic, mental disorders (dementia, delirium, and brain injury)
2. (F10–F19) Mental and behavioural disorders due to use of psychoactive substances (alcohol-use and substance use syndromes, including harmful use, dependence, and withdrawal)
3. (F20–F29) Schizophrenia, and schizotypal and delusional disorders
4. (F30–F39) Mood (affective) disorders (mania, hypomania, bipolar affective disorder, and depressive episodes)
5. (F40–F48) Neurotic, stress-related, and somatoform disorders (phobic anxiety disorder, panic disorder, generalised anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, adjustment disorder, dissociative disorder, and somatisation disorder)
6. (F50–F59) Behavioural syndromes associated with physiological disturbances and physical factors (eating disorders, sleep disorders, sexual dysfunction)
7. (F60–F69) Disorders of adult personality and behavior
8. (F70–F79) Mental retardation
9. (F80–F89) Disorders of psychological development
10. (F99) Unspecified mental disorders

Source: World Health Organisation, (1992)

Inclusion and Exclusion Criteria

The screening criteria for selecting respondents included the following:

- All patients must be in lucid interval before the interview
- The participants must be 20 years and above, both male and females
- Diagnosed of having a case of mental disease (F00-F99) at the three mental health facilities and either on admission or reporting for a review with the facility or going through therapy.
- Largely, the study targeted patients with anxiety, depression, mood disorders, alcohol disorders and schizophrenia. Patients must be people who were willing to respond to the questions on the interview schedule

with support from caregivers. Only those whose judgement was sound and were on maintenance drugs were interview. This was checked by the senior nurses in-charge.

- For facility personnel, must be working at the facility for at least three years and a Psychiatric, Senior Nurse, Administrator or Director of the facility.

Data Preparation and Procedure for Analysis

It employed multiple data analysis methods for the study giving its multidimensional nature. In the qualitative analysis for instance, various transcripts were typed and loaded into excel which allowed for classification of the interviews into themes and sub-themes. The study employed qualitative analysis separately, for example, caregivers, facility personnel or formal caregivers and outpatients were analysed. The researcher classified all the transcripts according to the desired themes and the responses of the participants. The effects of stigma for instance, discrimination was analysed and how it influenced availability of support, their understanding of these supports and the meanings they attached to it.

Quantitative analysis was multifaceted as results of multiple concepts that were involved. The first was to analyse demographic characteristics of patients. Because of multiple concepts in the measure, the study employed social negativity, structural, functional support as the three variables as well as mental and behavioural disorders (F00-F99) as the dependent variables. The study employed Statistical Package for Service Solution Version 20 to answer the objectives and test for the hypothesis. It employed Descriptive statistics to determine the summary statistics and then patterns and association between the variables and frequencies. It also generated frequencies, tables to study the various variables.

Again, it employed binary logistic regression model to answer the main questions on relationship between socio-demographic characteristics and social support variables on the mentally challenged. For instance, social support variables were re-grouped or collapsed into categorical, two main aspects, thus whether a patients had a friend or had a family and supported by significant others or not and whether a patient received a group member or not in that order. Zero (0) represented no friend and no support from friends, family members or significant others whiles one (1) represented the presence of friend or friends.

Fieldwork Challenges

Initially, we were going to interview close to 900 patients, but the decongestion exercise by the hospital authorities have resulted in scaling the number down to 409. This was a situation where some of the patients were allow to go home and be with their family members as results of financial challenges in feeding them. This number, was also determined by the number of patients that were in lucid interval, thus in touch with reality and willing to answer the questions. This made the number of patients who were willing to answer the questions reduced to 409 persons.

Ethical Considerations

The protocol for the study was submitted to the Ghana Health Service Ethical Review Committee in Accra for approval to use patients' admission register and records at the three psychiatric hospitals. In addition, permission was sought to engage and illicit information from mentally challenge patients attending the hospital or on admission and their caregivers at the same facilities.

Strict confidentiality was ensured by treating any information from respondents as private and for the purpose for this study. Anonymity was assured by the use of pseudonyms or codes to identify participants so that no personnel identified would be available to link participants to the information they provide. For participants who can neither read nor write, the informed consent form was read to them in the language they understand. Moreover, witnesses and interpreters were made to sign the informed consent form on behalf of the participants who could not give consent. The same protocol was submitted to the Institutional Review Board of the University of Cape Coast for review and approval (Appendices).

Summary

The chapter provided the philosophical background guiding the choice of method and approaches employed in answering the questions to this study. The study employed quantitative approach to answer the questions on structural, negative and sources of social support, which included the functional, structural, and negative support. Then again, it employed qualitative approach to answer questions on functional supports, care giving experiences and constraints of caregivers as well as policies at the various facilities. Correspondingly, there were areas where both methods were employed to get both quantitative and qualitative findings as well as supporting each question with the two paradigms.

CHAPTER SIX

TYPES OF SOCIAL SUPPORT AND SOURCES FOR THE MENTALLY CHALLENGED

Introduction

This chapter presents the results on characteristics of participants and diagnoses seen across the facilities. It also presents results and discussions on types of social support as well as sources for the mentally challenged in the various facilities and communities. A further analysis on the likelihood of sources of social support from the family, friends and significant other is employ by the use of binary logistic regression model. Similarly, structural support referred to as social network thus, existence of friends, group members and relatives for the mentally challenged while on admission is also analysed.

Characteristics of Respondents

In-Patients

Table 5 presents the results on background characteristics of the in-patients. A large majority (87 percent) of in-patients surveyed were in age range of 20 to 39 years. For instance, those aged 20-29 constitute 41.6 percent, whiles those aged 30-39 represent 45 percent respectively. The least (2 percent) were patients aged 50 and above. It is noticed that most patients on admission were young.

Table 5: Characteristics of In-Patients

Characteristics	Frequency	Percent
Age (N=409)		
20-29	170	41.6
30-39	184	45.0
40-49	47	11.5
50+	8	2.0
Marital status(N=408)		
Single/Never married	284	69.6
Married	60	14.7
Sep/divorced/widow	64	15.7
Education (N=408)		
Basic	146	35.7
Secondary	145	35.5
Tertiary	117	28.7
Gender (N=409)		
Male	261	63.8
Female	148	36.2
Types of family (N=409)	226	55.3
Nuclear	183	44.7
Extended		
Religion (N= 409)		
None	7	1.1
Muslim	73	17.8
Christian	324	79.4
Traditional	5	1.0
Ethnicity(N=409)		
Akan	186	45.6
Ga/Dangme	74	18.1
Ewe	72	17.4
Guan	7	1.7
Mole-Dagbani	6	1.5
Grusi	11	2.7
Gruma	4	1.0
Others	49	12.0

Table 5:Continued

Place (N=408)		
Urban	385	94.1
Rural	23	5.4
Employment (N=408)		
Unemployed	176	43.0
Employed	232	56.5
No. of Kids N (409)		
0	255	62.2
1-2	107	26.2
3+	47	11.5
Household size (N=408)		
1- 5	239	58.4
6 – 10	108	26.4
11-15	37	9.0
16 -22	24	5.5
Parents (N=403)		
Dead	125	30.6
Alive	278	68.0
Duration (N=401)		
<1yr	125	30.6
1-3yrs	102	24.9
4-5yrs	69	16.9
6-9yrs	38	9.3
10+	67	16.4
Income levels(N=387)		
200-499	220	53.8
500+	167	40.8
Church Att. (N= 402)		
Once	126	30.8
2-3	112	27.4
4+	164	40.1
No. Children (N=408)		
0	254	62.1
1-2	131	32.0
3+	23	5.6

Table 5:Continued

Diagnoses N 409		
F00-F09	6	1.5
F10-F19	120	29.3
F20-F29	164	40.1
F30-F39	82	20.0
F40-F48	14	3.4
F70-F79	9	2.2
F99/G40	12	2.9
Missing systems	2	0.5

Source: Fieldwork (2017)

Table 5 presents the results on marital status of in-patients. Majority (70 percent) of the inpatients were never married and about 16 percent of them were either divorced, separated or had lost their spouses. The analysis shows that majority (94 percent) of the in-patients seen across the facilities were from urban areas and the least (5.4 percent) were from the rural areas.

Gender background of patients shows that a large majority (64 percent) were males compared to females (36 percent). Again, employment status of in-patients shows that a greater majority (57 percent) were either formally employed or were in informal sector. However, 41 percent of them were not in any employment before the admission. The respondents were also analysed based on the types of family system they belonged. From Table 5, more than half (55 percent) of the in-patients seen were from a nuclear family system which comprises of parents and siblings. Religious background show that a large majority (79 percent) of the patients were Christians while the second largest (18 percent) were Muslims.

Table 5 also, gives a range of diagnoses (F00-F99) across the three facilities among in-patients. In all, 409 in-patients (45.4 percent) were surveyed out of a targeted number of 900. This number represents the total number of patients who were cleared to be in lucid interval (recovering or those in touch with reality) to respond to the questionnaires at the time of the study.

Ranges of diagnoses based on WHO International Classification of Mental and Behavioural Disorders, Tenth Revision (ICD-10). The highest proportion (40 percent) of the in-patients surveyed had schizophrenia, schizotypal, and delusional disorders (F20-F29) across the facilities. Mental and behavioural disorders due to the use of psychoactive substances (F10-F19) constitute the second highest diagnoses (about 29 percent) among in-patients across the facilities. This condition is because of the use of alcohol, other substance use syndromes including harmful use, dependence and withdrawal. There were other unspecified conditions F99, and a few number of patients who were epileptic, G40 (about 3 percent). From the results, it is notice that schizophrenia and alcohol use were among the common cases across the three facilities in Ghana.

Outpatients

Socio-demographic characteristics of twenty-three (23) outpatients who commute from the community to the three facilities for treatment were surveyed (Table 6). They were aged between 18 and 59 years. Nine of them were age 30 to 39 years, while one was aged above 50 years. Thirteen (13) of them were males, while ten were females. Three of the outpatients had never had any formal education, whereas ten of them had attained tertiary level of education.

Table 6:Socio-Demographic Characteristics of Outpatients

Characteristics	Frequency	Percent (%)
Age		
<20	3	13
20-29	8	35
30-39	9	39
40-49	2	8.7
50-59	1	4.3
Gender		
Male	13	56.5
Female	10	43.5
Marital status		
Married	7	30
Never married	15	65
Divorced	1	4.3
Education		
None	3	13
Basic	4	17.4
Secondary	6	26
Tertiary	10	43.5
Religion		
Christian	21	91.3
Islam	2	8.7

Source: Fieldwork, (2017)

Types of Social Support

Rodriguez and Cohen (1998) conceptualise social support as material and psychological resources available to individuals through their interpersonal relationship. Social support refers to the emotionally sustaining qualities of relationships (e.g., a sense that one is love, cared for, and listened to). Hundreds of studies have proven that social support benefits mental and physical health

(Uchino 2004). Two types of social support are discuss under this chapter (Table 7). These are; functional and structural social support.

Functional Social Support

The interview results show that the family and friends accepted some of the patients. Some of them were also comforted and encouraged. Family and pastors who offered prayers for them occasionally visited some of them (Table 7). Making one feel important is also some of the emotional supports received from the family and others. Some patients resorted to the teachings in the Bible to console themselves and believing that God in his own wisdom will heal them someday. Some family and friends for the patients also provided instrumental support, which is also tangible. Patients received money, which is family commitment to remit the patients on monthly basis. Others also do receive food and other services such as buying of drugs, washing of clothes, which cushion them as they cope with the condition.

Another key social support, which was provide for patients by family, friends or significant others, were taking patients to hospital on their due dates for drugs. Others also received support such as assurance, love from their wives or husbands to be there when things are difficult; they are always encouraged not to give up. Apart from perception of emotional support, others also perceived availability of actual support. For example, financial support to buy drugs, cook; provide food and being in company of uncle and aunt smoking together.

Table 7: Themes on Functional Social Support Received

Themes	Sub-categories
Emotional Support	• Acceptance by family and friends • Comfort, encouragement not to give up • Visitation, talk and offer prayers • Making one feel important • Bible and the teachings also console oneself with God • Counselling services
Instrumental Support	• Money, food, clothes • Thread and needle • Washing of clothes • Buying drugs, cooking • Monthly salary from family • Taken to the hospital for review • Former boss at previous place of work will call and ask of condition • Support from Evangelism Leader
Informational Support	• Advice to avoid dangerous activities and places • Advice to cook and sell • Advice from doctors to take medicine and not to give up on life. • Taking drugs on time

Source:Fieldwork (2017)

Emotional Social Support

A female graduate of 25 years who is employed had Schizophrenia and schizotypal and delusional disorders (F20-F29) for more than 5 years. She elaborated on how she received emotional support from her mother who considers her everything;

After my second episode, I found myself naked and people have to know. I wanted somebody to tell me what happened to me. I wanted to do the last thing, suicide, but my mother gave me hope, she changed my mind, she values me, show concern, do everything for me. I am coping and I want you to work on stigmatisation' (A 25-year-old female patients).

A 24 years old male who is schizophrenic said:

'I feel okay as a normal condition everybody goes through I am outgoing person; my friends do not know about my condition so I feel fine I cannot tell if they know about the condition their attitude could change. My mom is around to cheer me up most of the time. My senior brother supports financially but all my comfort, help is from my mom. At school, I have one friend, Abigail who also helps me feel like she cares about me but my mom is always there for me'

(A 24-year-old male patient).

Similarly, a male with schizophrenia recounted emotional support from his mother and father as:

"My mother and my dad show me love and cheers me up. My mother is always around me and brings me to the hospital for review. They both encourage me to take my drugs on time. Every moment they will tell me everything will be fine"

(A 34-year-old male patient).

A 30-year-old graduate patient takes consolation and encouragement from the wife and pastor as:

"My pastor talks to me always. He encourages me and pray for me. My wife help; she is supportive. I have a child who comforts me with my wife. They give me hope that all will be fine" (A 30-year-old Male patient).

Instrumental Social Support

On these forms of support, a female Psychiatric Nurse In-charge in one of the facilities with 15 years of working experience in psychiatry said:

"Nurses at certain times also use their own money to provide material support such as food especially at the time of medication and during emergencies. They also provide clothe for the patients" (A female Nurse In-charge).

A 35-year-old patient talks about some of the instrumental supports he receives from the family and his boss at work. He narrated that:

"My mom buys credit for me and sometimes gives me pocket money from my junior brother. My boss at work guides me and help me perform a task. My dad also helps in buying the drugs at due dates and assists me take them on time. My junior brother also helps me wash my clothes when I am weak" (A 35 year-old male patients).

A 33-year-old female who is mentally ill for 6 years recounted instrumental support from the mother and brother for the past six years of this condition as:

"My brother provides money for my upkeep. He visits me, buys my drugs for me, and sometimes provide cloth and food for me. My family is also there for me. They provide food and help me wash my cloths when I am down. I have a friend also who visits me and talk with me" (A 33-year-old female).

Informational Social Support

Informational social support involves advice-giving, education on the most diagnoses provided for patients (Table 7). This guides them in taking their drugs. Some family members also, counsel their patients to avoid places that will be injurious to them. Some patients were also advice depending on their condition to cook and sell so as not to depend on family members. Besides, nurses do give information on patients' condition and treatment through health promotion during morning talks at the wards. In some facilities, some patients receive talk on their condition every morning on their treatment. Each morning, there is a talk by therapeutic community in the ward on current affairs (Table 7). A senior Nurse In-charge of one the facilities said:

"Patients get information from Doctors and Nurses on causes, treatment and prevention. This happens every day through our health promotion program. It happened at the Psycho OPD or by a group called Therapeutic Community. We also encourage the patients to ask questions for necessary information" (A female senior Nurse In-charge).

On giving information on how to cope, a female patient said she has been counsel on how to make her own income but to be careful of fire as:

"A woman in my church has advise me to find a way of cooking and selling. This will help me not to be too much dependent on people but I was also advice not to be closer to fire because when the sickness come I could fall and when I am closer to fire it could be dangerous for me" (A 20-year-old female patient).

Structural Social Support

Table 8 provides information on structural aspect of social support. This includes the number of close friends available to patients, number of times visited by relatives as well as talking with them and number of times neighbours or group members visit patients in the last month before interview. The results show that overall, about 31 percent of patients do not have any close friends, while 57 percent of them had close friends between one (1) and three (3). Again, on number of times, patients received group members or neighbours as visitors whiles on admission shows that about 59 percent of the patients do not receive any visitor while 33 percent of them received visitors between 1 and 3 occasions in a month.

Table 8-Structural Social Support by Socio-Demographic Characteristics

	Structural Social Support %										
Variable	NCFs			NN/GV			NRsTV			X^2	p-value
	0	1-3	4+	0	1-3	4+	0	1-3	4+		
Age	30.9	57	12.2	58.5	33.2	8.5	27.4	52.2	20		
20-29	23.7	59.2	17.2	62.8	36.5	6.7	23.2	60.7	16.1		
30-39	33.0	56.6	10.4	64.4	27.8	7.8	29.6	48.0	22.3	8.095	0.344
40+	49.1	43.4	7.5	66.0	28.3	5.7	35.8	41.5	22.6		
Mari.										14.705	0.013
Single	34.4	51.4	14.4	70.2	25.1	4.7	30.8	53.0	16.1		
Married	22.0	74.6	3.4	53.3	38.3	8.3	20.3	49.2	30.5		
Sep/D	24.2	59.7	16.1	45.9	37.7	16.4	19.7	54.1	26.2		
Edu.										15.94	0.027
Basic	46.2	42.7	11.2	68.3	24.5	7.2	34.0	42.6	23.4		
Sec.	25.9	56.6	17.5	24.6	56.3	19.0	24.6	56.3	19.0		
Tertiary	18.8	71.8	9.4	63.5	30.4	6.1	24.1	59.5	16.4		
Gend.										4.354	0.584
Male	28.6	54.8	16.6	65.8	26.8	7.4	26.8	51.4	21.8		
Female	35.9	57.9	6.2	60.7	32.9	6.4	29.4	54.5	16.1		
Chur.										10.14	0.053
Once	39.2	49.6	11.2	71.8	22.6	5.6	36.8	50.4	12.8		
2-3	31.8	60.0	8.2	64.2	29.4	6.4	23.1	57.4	12.8		
4+	24.1	58.0	17.9	56.7	34.4	8.9	24.2	50.3	25.5		
Dura.										18.944	0.005
<1yr	16.9	70.2	12.9	58.5	38.1	3.4	25.4	57.4	17.2		
1-3yr	22.5	61.8	15.7	73.0	23.0	4.0	20.8	56.4	22.8		
4+yr	46.2	43.3	10.5	10.5	62.8	26.2	34.5	45.6	19.9		
Dura.										18.944	0.005
<1yr	16.9	70.2	12.9	58.5	38.1	3.4	25.4	57.4	17.2		
1-3yr	22.5	61.8	15.7	73.0	23.0	4.0	20.8	56.4	22.8		
4+yr	46.2	43.3	10.5	10.5	62.8	26.2	34.5	45.6	19.9		

Source:Fieldwork (2017)

***NCFs means number of close friends ***NN/GV implies number of time group members or neighbours pay vi to patients whiles on admission every month. *** NRsTV implies number of relatives seen and talked to in a mont

In addition, the number of relatives who visit or talk to patients in the month shows that 27 percent of patients do not see or talk to any relatives in a month whiles 52 percent of them do talk to relatives between one (1) and three (3) in a month. It can be realised that a large majority of patients do not receive visitors from their group such as church, clubs work mates while on admission.

Information on age suggests that a greater proportion of patients aged 40 and above (49 percent) were not having any close friends compared to patients aged 20-29 (24 percent). The results indicate that patients aged 20-29 (61 percent) see and talk to between 1 and 3 relatives in a month compared to 41 percent of patients aged 40 and above.

Information on marital status and structural social support (Table 8) show that two thirds (75 percent) of patients who were married had between 1 and 3 close friends compared to 51 percent of patients who were single. Again, a quarter of patients who were married (38 percent) received between 1 and 3 neighbours and group members as visitors while on admission compared to 25 percent of the single. But, there were slightly higher proportion of patients who were single (53 percent) who see and talk to relatives between 1 and 3 in a month compared to proportions of patients who were married which is, 49 percent (X^2= 14.705, P<0.013).

Table 8 examines patients' level of education by number of friends or group members who pay visits while on admission. The results show that proportion of patients with number of close friends between one (1) and three (3) increases with higher education. For instance, proportion of patients (42.7 percent) who have attained basic education level had close friends of between one (1) and three (3). Similarly, the proportion of patients with secondary education increases (56.6 percent) and further to two third (71 percent) among patients who had attained tertiary education level ($X^2=15.94, p<0.027$). From the results, there is a difference in proportions of patients with number of close friends and educational level.

Employment status of patients indicates that the proportions of patients (about 63 percent) who were employed had close friends of between one (1) and three (3) compared to the proportions of patients (47 percent) who were unemployed. Again, on number of group members and neighbours who visit patients on admission, about 40 percent of patients who were employ had between one (1) and three (3) group members or neighbours as visitors compared to 22 percent of patients who were unemployed. It can be realised from the results that a greater proportion of patients who were employed had number of close friends of 1 to 3 as well as received group members and neighbours as visitors than patients who were unemployed ($X^2=14.212, p<0.018$).

Finally, duration of stay at the hospital and number of friends shows that greater proportions of patients with less than a year stay at the hospital (70 percent) had close friends between one (1) and three (3) compared to proportions of patients with more than a year stay at the hospital (63 percent). In the same vein, proportion of patients with longer stay at the hospital (43 percent) who had close friends of one (1) and three (3) reduces. Greater proportions of patients with less than a year stay at the hospital (57 percent) talk and see relatives of between one (1) and three (3) in a month compared to proportions of patients (46 percent) with more than 4 years stay in the hospitals. From the results, it can be seen that patients with less than 6 months stay had more close friends and interact with relatives than patients with a longer stay at the hospital ($X^2 = 18.944$, $p < 0.005$).

Structural Social Support among Friends

Table 9 presents results on the likely hood of having a close friend or friend's whiles on admission among patients. Having a close friend is a form of social support one can depend on, and talk to in times of trouble. From the results, patients aged 30 and above were less likely to have a friend of one (1). For instance, patients age 40 and above were less likely to have a close friend of one (1) or more (OR= -0.192, $p<0.000$) compared to patients aged 20-29. Again, on marital status, the results, suggest that both patients who were married or divorced were more likely to have a close friend of one or more (OR = 2.447, $p<0.031$, OR 3.523, $p<0.003$) compared to patients who were single. From the results, patients who were divorced or separated were three times more likely to have close friends compared to patients who were married who were twice more likely to have close friends.

Patients' educational level and likelihood of having close friends show that as patients' educational level increases, the likelihood of having close friends also increases. For example, patients who had attained tertiary level of education were about twice more likely to have close friends of one or more (OR= 2.916, $p<0.001$) compared to patients who had attained basic education level (Table 9).

Table 9: Logistic Regression Estimates of Having Close Friends

Variable	B	S.E	Wald	df	p-value	O.R	95% CI	
Age			16.105	2	0.000		L	U
20-29 Ref								
30-39	-0.851	0.277	9.408	1	0.002	0.427	0.248	0.736
40+	-1.651	0.444	13.817	1	0.000	0.192	0.080	0.458
Marital			10.294	2	0.006			
Single Ref								
Married	0.907	0.422	4.22	1	0.031	2.477	1.084	5.659
Sep/Divorce	1.259	0.424	8.842	1	0.003	3.523	1.536	8.080
Education			12.687	2	0.002			
Basic Ref								
Secondary	0.662	0.278	5.684	1	0.017	1.939	1.125	3.341
Tertiary	1.070	0.316	11.458	1	0.001	2.916	1.569	5.419
Gender								
Female Ref								
Male	0.479	0.262	3.350	1	0.067	1.615	0.967	2.698
Employment								
Unempl Ref								
Employed	0.759	0.254	8.926	1	0.003	2.137	1.298	3.516
Church Att.			6.525	2	0.038			
Once Ref								
2-3	0.184	0.310	0.552	1	0.552	1.203	0.655	2.208
4+	0.718	0.291	6.086	1	0.014	2.049	1.159	3.624
Constant	-393	0.360	1.194	1	0.275	0.675		

Source: Fieldwork (2017)

In effect, the results suggest a strong relationship between education and the likelihood of having a close friend among patients.

Patients' employment level and likelihood of having a close friend also suggest that patients who were employed were more than two times likely to have close friends (OR=2.137, p<0.003) compared to patients who were unemployed. The estimates on church and mosque attendance also suggest positive relationship between having close friends and frequency of church attendance. For example, patients who attend church/mosque for more than four times in a month were more than twice likely to have close friends compare to friends who attend such services once in a month (0R = 2.049, p<0.014).

Receiving Group Members/Neighbours as Visitors whiles on Admission

Table 10 presents logistics regression of receiving visitors by patients whiles on admission. As a policy, the mental health facilities have an open door policy to encourage communities, groups and families to visit their loved ones at the facilities. This is to enhance social support among patients at the facilities. The results suggest that patients aged 30 and above were less likely to receive group members or neighbours as visitors while on admission. For instance, patients aged 40 and above were less likely to receive any group member or neighbours each month as visitors (OR= -0.421, p<0.035) compared to patients aged 20-29 years.

On marital status, patients who were married were more likely to receive group members, neighbours as visitors from one group or more each month of their stay at the hospital (OR= 2.182, p<0.025) compared to patients who were single or never married. The effects were however stronger for patients who were divorced as they were three times more likely to receive visitors as compared to patients who were married and who were two times more likely to receive visitors.

Finally, patients who attend church/mosque for more than four times in a month were also found to be about 74 percent more likely to receive neighbours and other group members as visitors (OR=1.737 p<0.042) compared to those who attend church only once in a week.

Table 10: Logistic Regression Estimates on Receiving Group Members/ Neighbours as Visitors whiles on Admission

Variable	B	S.E	Wald	df	p-va	O.R	95% CI	
Age			5.821	2	0.054		L	U
20-29 Ref								
30-39	-0.534	0.263	4.120	1	0.042	0.586	0.350	0.982
40+	-0.866	0.412	4.429	1	0.035	0.421	0.188	0.942
Marital			15.270	2	0.000			
Single Ref								
Married	0.780	0.349	4.999	1	0.025	2.182	1.101	4.324
Sep/Divorce	1.340	0.350	14.659	1	0.000	3.820	1.9240	7.587
Employment								
Unempl Ref								
Employed	0.445	0.240	3.438	1	0.064	1.561	0.975	2.500
Church Att.			4.612	2	0.100			
Once Ref								
2-3	0.155	0.298	0.270	1	0.603	1.168	0.651	2.096
4+	0.552	0.272	4.113	1	0.042	1.737	1.020	2.957
Constant	-1.117	0.355	9,896	1	0.002	0.327		

Source: Fieldwork (2017)

In Table 10, results on employment suggest that patients who were employed were more likely about 56 percent to receive visitors and neighbours (OR = 1.561) compared to patients who were unemployed.

Seeing and Talking to Relatives in a Month whiles on Admission

Table 11 presents results on the likelihood of seeing and talking to relatives at least once in a month whiles on admission. On age, the results show that patients aged 30 and above were less likely to see and talk to relatives at least once in a month whiles on admission. For example, patients aged 40 and above were less likely to see and talk to any relatives at least once in a month (OR= -0.371, p<0.017) compared to patients aged 20-29 years.

On marital status, patients who were married were more likely to see and talk to their relatives at least once or more times in the month respectively (OR = 2.176, p<0.054) compared to patients who were single. The analysis shows that whiles patients who were married were about 2 times more likely to see and talk to relatives whiles on admission for once or more times, patients who were divorced or separated were also more than 3 times more likely to see and talk to relatives compared to patients who were single.

Table 11: Logistic Regression Estimates of Seeing and Talking to Relatives in a Month whiles on Admission

Variable	B	S.E	Wald	df	p-v	O.R	95% Cl	
Age			7.149	2	0.028		L	U
20-29 Ref								
30-39	-0.579	0.237	4.690	1	0.030	0.560	0.332	0.946
40+	-0.993	0.417	5.667	1	0.017	0.371	0.164	0.839
Marital			7.817	2	0.020			
Single Ref								
Married	0.777	0.403	3.726	1	0.054	2.176	0.988	4.792
Sep/Divorce	1.020	0.406	6.310	1	0.012	2.773	1.251	6.144
Employment								
Unempl Ref								
Employed	0.293	0.249	1.379	1	0.240	1.340	0.822	2.184
Church Att.			4.315	2	0.116			
Once Ref								
2-3	0.525	0.310	2.874	1	0.090	1.690	0.921	3.100
4+	0.508	0.276	3.393	1	0.065	1.662	0.968	2.854
Constant	0.303	0.349	0.752	1	0.386	1.354		

Source: Fieldwork (2017)

Sources of Social Support

Thoits (2010) conceptualises social support as emotional, informational or practical assistance from significant others, family members, friends or co-workers and that support actually may be received from others or simply perceived to be available when needed. A bivariate analysis on sources of social supports by socio-demographic backgrounds is presented in Table 12. In general, all patients sampled mentioned various sources of social support from the family (54.9 percent) significant others (61 percent) and friends (27 percent). However, the proportion of the sample (27 percent) with access to social support from friends is lower compared to social support from the rest of the sources (family and significant others).

Among the age groups, social support from friends was generally low. For instance, only 32.9 percent of patients aged 20 to 29 could point to friends as their source of social support and this reduced further to 18 percent among patients aged 40 and above. Marital status of patients (Table 12) indicates that two-third (70 percent) of patients who were married mentioned social support from the family compared to 51 percent of the patients who were single.

Table 12: Sources of Social Support by Socio-Demographic Characteristics

	Sources of social support %							
Variable	Family		S.O		Friends			
	Yes	No	Yes	No	Yes	No	X^2	P-value
	54.9	45.1	60.9	39.1	26.9	73.1		
Age							2.671	0.380
20-29	58.2	41.8	57.1	42.9	32.9	67.1		
30-39	51.1	48.9	51.4	48.6	25.3	74.1		
40+	56.4	43.6	52.7	47.3	18.2	81.8		
Marital							7.690	0.028
Single	51.4	48.6	57.8	42.2	26.6	73.4		
Married	70.0	30.0	78.3	21.7	40.0	60.0		
Divorced	36.2	43.8	68.8	31.3	20.3	79.7		
Education							6.515	1.624
Basic	56.2	43.8	58.3	41.7	14.4	85.6		
Secondary	62.1	37.1	58.6	41.6	18.2	81.8		
Tertiary	40.2	59.8	62.3	37.7	25.0	75.0		
Gender							1.7977	0.2056
Male	58.6	41.4	63.1	36.9	29.1	70.9		
Female	48.0	52.0	61.2	38.3	24.7	75.3		
Family							0.918	0.121
Nuclear	52.2	47.8	49.1	50.9	23.9	76.1		
Extended	57.9	42.1	59.9	40.1	32.0	68.0		
Religion							6.0833	0.26
Christian	55.9	44.1	64.0	36.0	27.6	72.4		
Islamic	57.7	42.5	60.3	39.7	28.8	71.2		
Others	27.3	72.7	27.3	72.7	18.2	81.8		
Place							7.19	0.222
Urban	55.3	44.7	63.2	36.8	27.2	72.8		
Rural	50.0	50	54.5	45.5	36.4	63.6		
Employment							11.017	0.014
Employed	61.5	38.5	66.4	33.6	36.2	63.8		
Unemployed	46.6	53.4	57.4	42.6	15.9	84.1		
H. holdsize								
1-5	53.1	46.9	50.6	49.4	25.1	74.9	8.102	0.048
6-9	51.9	48.1	50.0	50.0	24.1	75.9		
10+	66.7	33.3	72.7	27.3	44.8	55.2		
Income								
200-499	49.5	50.5	57.3	42.7	25.2	74.8	4.639	0.033
500+	62.3	37.7	68.7	31.1	32.3	67.7		
Parents								
Dead	40.8	59.2	55.3	44.7	19.2	80.8	8.376	0.014
Living	61.2	38.8	65.8	34.2	31.7	68.3		

Source: Fieldwork (2017)

Similarly, sources of social support from significant others show that 78 percent of patients who were married point to these supports from the significant others compared to 58 percent of patients who were not married. It can be realised from the results that a large proportion of patients who were married could have access to social support from the family as well as significant others compared to proportions of patients who were single or divorced ($X^2 = 7.690$, $p<0.028$).

Information on gender and sources of social support shows that majority of males (58 percent) mentioned they could draw on social support from the family compared to females (48 percent). Social support from friends also show that a slightly marginal proportion of male patients (29 percent) mention this support than females (25 percent). The result suggests that a higher number of male patients mentioned social support from the three sources than females (Table 12).

Place of residents and sources of social support reveals that more than half of patients (55 percent) from urban area who mentioned social support from family were greater than proportion of patients from rural area (50 percent). However, the proportions of patients (36 percent) who mentioned they could depend on friends for social support were greater than urban areas (27 percent).

Table 12 similarly, presents results on respondents' employment status and sources of social support. The result suggests that greater number of patients (62 percent) who were employ mentioned family as a source of their social support compared to the unemployed (47 percent). Again, a greater share (36 percent) of patients who were employ mentioned friends as a source than the unemployed (16 percent). ($X^2 = 11.017$, $p<0.014$).

Household size and sources of social support among patients is also examine in Table 12. The results indicate that as household size increases, the proportion of patients with social support from the three sources also increases. For instance, about 67 percent of patients from household size of 10 or more members received social support from the family compared to 53 percent of patients from a household size of 1-5 members. It is seen from the results that there is significant difference in the proportion of patients from households of 10 or more members and patients from household of 1-5 members in the social support ($X^2 = 8.102$, $p<0.048$).

Finally, patients' income levels and sources of social support show that a greater proportion of patients with income level above 500 Ghana cedis reported social support from the family (62.3 percent) compared to patients whose income were below 500 Ghana cedis. Again, proportion of patients who get support from significant others is 68.7 percent whiles 32.3 percent reported having been supported by friends. From the results it can be seen that proportion of patients with higher income thus above 500 with access to social support from the three sources were higher compared to patients whose income is below 500 Ghana cedis ($X^2= 4.639$, $p<0.033$).

Social Support from the Family.

Results on patients' likelihood of getting social support from the family by various demographic characteristics is presented in Table 13. It was found that patients aged 40 and above were less likely to receive social support from the family (OR -0.435, $p<0.027$) compared to patients aged 20-29 years. Again, on marital status of patients, those who were married were more likely to receive social support from the family (OR= 2.047) compared to those who were single.

Educational level of patients also shows that patients with tertiary level of education were more than two times likely to receive social support which could be emotional or instrumental from the family (OR 2.527, p<0.002) compared to patients with basic level of education.

Table 13: Logistic Regression Estimates on Socio-Demographic Characteristics and Social Support from the Family

Variable	B	S.E	Wald	Df	p-value	O.R	95% CI	
Age			8.222	2	0.016		L	U
20-29 Ref								
30-39	-214	0.422	0.257	1	0.612	0.807	0.353	1.847
40+	-833	0.3766	0.376	1	0.027	0.435	0.208	0.908
Marital			4.112	2	0.128			
Single Ref								
Married	0.716	0.379	3.564	1	0.059	2.047	0.973	4.307
Sep/Divorce	-0.011	0.358	0.001	1	0.975	0.989	0.491	1.993
Education			11.31	2	0.003			
Basic Ref								
Secondary	0.719	0.271	7.024	1	0.008	2.053	1.206	3.495
Tertiary	0.927	0.279	9.712	1	0.002	2.527	1.411	4.527
Gender								
Female Ref								
Male	0.691	0.251	7.566	1	0.006	1.995	1.220	3.263
Employment								
Unempl Ref								
Employed	0.656	0.241	7.423	1	0.006	1.926	1.202	3.087
Duration yr.			4.997	2	0.082			
<1 Ref								
1-3	-0.566	0310	3.564	1	0.068	0.568	0.309	1.043
4+	-0.602	0.291	4.272	1	0.039	0.548	0.309	0.969
Church Att.			10.564	2	0.005			
Once Ref								
2-3	0.752	0.301	6.235	1	0.013	2.122	1.176	3.829
4+	0.856	0.279	9.442	1	0.002	2.354	1.364	4.065
Constant	-466	0.499	0.874	1	0.350	0.627		

Source: Fieldwork (2017)

It shows that the level of social support increases with higher education.

Another finding is that, male patients were more likely to receive social support (OR 1.995, p<0.006) compared to female patients. From Table 13, it is seen that patients who were employed were more likely to receive social support from the family (93 percent, times OR 1.926, p<0.006) compared to patients who were unemployed. Duration of stay at the hospital and likelihood of getting social support from the family (emotional and instrumental) show that patients with a longer stay (above 4 years) were less likely to receive these support from the family (OR = -0.548, p<0.039) compared to patients with less than six month stay at the facilities. It has been noticed that a longer stay at the facilities lead to less provision of social support at the facilities.

Church/Mosque attendance (Table13) and provision of social support for instance, emotional or instrumental, from the family shows that patients who attend church service for more than four times in a month were more than twice likely to receive social support from the family (OR= 2.354, p<0.002) than those patients who attend church only once in a month. The results suggest that frequency of mosque or church attendance comes with an increasing social support from the family.

The hypothesis tests the relationship between socio-demographic variables (age, education, household size, church attendance and parents living or dead) and sources of social support from the family. The results presented in Table 14. According to Fournier (2011), the best source as well as the greatest source of social support and comfort is from the family members. In most African countries as well, cultural values are cherish and have been built around relationships as described in Gyekye (1996) Maxim's philosophy.

Table 14 :Regression Output of Hypotheses

Variable	B	SE	Wald	P	95% CI Conf. Interval	
Age	-0.365	0.210	3.008	0.083	0.460	1.049
Education	0.531	0.161	10.887	0.001	1.240	2.330
Church/M Att.	0.355	0.157	5.103	0.024	1.048	1.9442
Parents	0.686	0.330	4.309	0.038	1.039	3.793
Household size	0.311	0.170	3.365	0.067	0.979	1.904
Constant	-3.424	0.756	20.498	0.000		

Source: Fieldwork (2017)

Table 14 shows that the independent socio-demographic variables accounted for 77.2 percent of the total variations. This means that other factors not included accounted for 22.8 percent of the variation. All the variables have some sort of relationship with getting social support from the family, which made the family crucial and alternative source for social support especially in recovery process of the mentally challenged. The null hypothesis therefore that there is no relationship between these variables and sources of social support from the family is rejected. This finding thus supports the integrated approach in treating mental health problem by WHO (2013), where community centred approach is a processes where stigma is broken when mentally challenged stay in the communities.

Social Support from Significant Others

Table 15 presents the results on the likelihood of receiving social support from the significant others. It can be seen that patients aged 30-39 were less likely to receive social support from the significant others (OR= -0.586, $p<0.050$) compared to patients aged 20-29 years. In addition, on marital status, patients who were married were more likely to receive emotional and instrumental support from significant others (OR = 2.199, $p<0.042$) compared to patients who were single or divorce or separated.

Table 15 presents' results on educational level of patients and the level of instrumental and emotional social support from significant others. The result suggests that patients who have attained tertiary level of education were more likely to receive social support which could be instrumental and emotional from significant others (about 70 percent, OR = 1.700) compared to patients with basic or secondary level of education. Likewise, patients who were employed were more likely to receive social support from significant others (about 61 percent, OR=1.608, $p<0.046$) than patients who were not employed before admission. Duration of stay at the hospitals as seen in Table 15 shows that the longer patient stays at the hospital the lesser social support received.

For instance, patients with more than four years stay at the hospital were less likely to receive emotional social support from their significant others (OR= –0.427, $p<0.003$) compared to patients with less than 6 months stay at the hospital.

Finally, social support from significant others for patients who frequently attend church/mosque in a month points out a positive relationship between church attendance and social support. For example, patients who attend church for more than four times in a month were more likely to receive emotional and instrumental support from significant others (about 88 percent, OR= 1.884, $p<0.021$) compared to patients who attend church only once in a month.

Table 15: Logistic Regression Estimates on Source of Social Support from Significant Others.

Variable	B	S.E	Wald	Df	p-value	O.R	95% CI	
Age			3.859	2	0.149		L	U
20-29 Ref								
30-39	-534	0.272	3.858	1	0.050	0.586	0.344	0.999
40+	-0.412	0.413	0.99	1	0.318	0.662	0.295	1.487
Marital			5.327	2	0.070			
Single Ref								
Married	0.788	0.387	4.148	1	0.042	2.199	1.030	4.693
Sep/Divorce	-0.114	0.349	0.107	1	0.744	0.892	0.450	1.769
Education			5.713	2	0.057			
Basic Ref								
Secondary	-0.141	0.266	0.280	1	0.596	0.869	0.516	1.463
Tertiary	0.531	0.297	3.190	1	0.074	1.700	0.950	3.044
Employment								
Unempl Ref								
Employed	0.475	0.238	3.996	1	0.046	1.608	1.608	2.562
Duration yr.			9.692	2	0.008			
<1 Ref								
1-3	-0.783	0.311	6.343	1	0.012	0.457	0.248	0.840
4+	-0.851	0.591	8.573	1	0.003	0.427	0.241	0.755
Chu/Mos. At			5.662	2	0.059			
Once Ref								
2-3	0.194	0.295	0.432	1	0.511	1.294	0.681	2.166
4+	0.633	0.275	5.287	1	0.021	1.884	1.098	3.233
Constant	0.327	0.344	0.903	1	0.342	1.386		

Source: Fieldwork (2017)

Social Support from Friends

Table 16 presents the likelihood of receiving social support from friends by patients on admission. The results suggest that patients aged 40 and above were less likely to receive social support from friends (OR= -0.197, p<0.004) compared to patients aged 20-29 years. The results also suggest inverse relationship between social supports from friends and age because as a patient age, his/her instrumental and emotional support from friends reduces. On marital status, the results suggest a notable finding. It shows that patients who were married were more than twice likely to receive emotional and instrumental support from friends (OR= 2.545, p<0.025) compared to patients who were single.

Patients educational level and social support from friends show that patients with a higher level of education were more likely to receive these kind of social support (OR = 2.389, p<0.008) compared to patients who had attained basic level of education. The findings were notable, it similarly suggest that as patients' level of education increases, emotional support, and instrumental support as well increases.

Frequency of church or mosque attendance suggests an increase in social support from friends. For instance, patients who had attended mosque/church for more than four times were more than twice likely to receive emotional and instrumental support from friends (OR = 2.439, p<0.008) compared to patients who go to church once in a month.

Table 16: Logistic Regression Estimates on Source of Social Support from Friends

Variable	B	S.E	Wald	Df	p-value	O.R	95% CI	
Age			9.825	2	0.007		L	U
20-29 Ref								
30-39	-0.827	0.339	5.962	1	0.015	0.437	0.225	0.849
40+	-1.626	0.565	8.264	1	0.004	0.197	0.065	0.596
Marital			5.357	2	0.069			
Single Ref								
Married	0.934	0.415	5.055	1	0.025	2.545	1.127	5.745
Sep/Divorce	0.602	0.428	1.972	1	0.160	1.825	0.788	4.226
Education			14.440	2	0.001			
Basic Ref								
Secondary	-0.336	0.337	0.997	1	0.318	0.714	0.369	1.383
Tertiary	0.871	0.329	6.996		0.008	2.389	1.253	4.556
Employment								
Unempl Ref								
Employed	0.409	0,287	2.031	1	0.154	1.506	0.858	2.643
Church Att.			9.500	2	0.009			
Once Ref								
2-3	0.077	0.363	0.044	1	0.834	1.080	0.526	2.127
4+	0.891	0.334	7.117	1	0.008	2.439	1.267	4.694
Constant	-1.530	0.413	13.716	1	0.000	0.217		

Source: Fieldwork (2017)

Other studies have specified that receiving support from one's spouse relate to lower levels of distress (Druley & Townsend, 1998; Frazier, Davis-Ali, & Dahl, 1995; Schuster, Kessler, & Aseltine, 1990). In addition, partner support enhanced the coping ability and wellbeing of cancer patients, but worsened for unsupported patients. Other works in the field of social support showed positive main effect of receiving social support. For instance, Schulz and Schwarzer (2004) found that provided emotional, informational and instrumental support correlated moderately with received emotional support.

Huang, Sousa, Tsai, and Hwang (2008), examined the relationships among contextual factors, dimensions of social support, adaptations and psychiatric symptoms among mentally ill adults in hospital in Southern Taiwan. Their findings suggest that individuals who were older, male, independent and had higher education, a shorter duration of mental illness and fewer psychiatric symptoms, had higher life skills. Three dimensions of social support (belonging, tangible and self-esteem) moderated the relationship between psychiatric symptoms and number of hospitalisations. They conclude that life skills and social support play important roles in the adaptation of Taiwanese adults with mental illness in the community as well as in decreasing their psychiatric symptoms and number of hospitalisations.

There were patients who also received informational social support regarding their condition either from the health facility or from the community in which they lived. Some of them were advice on how to cope with the condition, such as regularly taking their drugs as well as signs that accompany with the drugs.

The findings on informational social support replicate the assertion of Mattson and Hall (2011) that this type of information is a communication that provides useful and needed information when one is facing, a challenge in order to make decisions. If one does not know the details of what he or she is, facing this could be a source of upset or stress (Mattson & Hall, 2011). When information on the condition is given and how symptoms will show when drugs are taken could lead to useful bit of information in managing the condition.

This information provision could help patients in adaptation where social support is a resource promoting adaptation to stressful situations. According to the proponent of the theory (Selye, 1975), general adaptation syndrome encompasses all non-specific changes that develop over time during continuous exposure to stressor attack (Selye, 1975). Apart from the biological perspectives on adaptation, also it has social dimension, which refers to the process of integration, psychological in which adaptation is conduit used to maintain a state of equilibrium between a subject and his or her environment. According to the Parkinsonian (2016), they suggested that seeking social support is a strategy that can help with depression and it might play an important role in lessening the degree of depression in Parkinson. It has been said that creating more fulfilling social relationships and learning to enjoy time alone as well as owning a pet and exploring new interests and hobbies such as joining support groups, clubs and other organisations in a way of strengthening one's relationship been found to improve Parkinson diseases which has linkages on mental health outcome.

Structural social support is existence of friends, relatives and frequency of interaction with group members. The results suggest that patients who were 40 years and above were less likely to have close friends of at least one, less likely to have group members as visitors and less likely to see and talk to relatives in a month while on admission. According to Cain (2012), older people are marginalised and stigmatised and face barriers in accessing social support services and therefore rendered invisible. Those above 40 are independent, and if they do not have a strong family with a strong family tie background to care for them, they could lack social resources especially friends.

The World Health Organisation (2005) for instance, declared that one of the aspects of good mental health is the ability for mutually satisfying and enduring relationships. They note that social relationships and networks act as protective factors against the on-set and recurrence of mental ill health. Additionally, interactions enhance recovery from mental disorders. Equally, development of infants is link to social interaction and WHO explained the fact that holistic development of children will not be complete without social interaction or social support (WHO, 2005). This could affect patients who fall in this category and could affect their recovery.

Again, patients who were married were more likely to have close friends, receive more group members as visitors as well as see and talk to relatives compared to those who were single. The benefit of network and friends for those who are married is explain in terms of beneficial relationship and marriage itself is seen to be social support. For example, an intimate partner can be a source of support in marital unions and partners are most likely to turn to each other for support in times of need (Beach, Fincham & Katz,1998). Similarly, Umberson and Montez (2010) stated three key types of social ties that could influence health of which spouses could draw benefit. These are behavioural, psychosocial and physiological in nature. Those who are widowed, separated or divorced could depend on their children and other family networks that may be a source of support for them.

Similarly, patients who were employ were more likely to have close friends, receive group members as visitors and were more likely to see and talk to relatives compared to patients who were unemployed. There is a linkage between education, employment and income. Patients with higher education could have more knowledge to seek for more information about their condition. Furthermore, with networks they could get a meaningful job that supports each other. People who were employ have more resources than those who are unemployed. These resources could be friends from work and other social clubs. Weyers, Dragano, Möbus, Beck, Stang, Möhlenkamp, Jöckel, Erbel and Siegrist (2008), found similar trend that people at disadvantage positions, are more likely to report poor social networks and social support. The findings also resonate with the call by WHO (2014), to tackle socio-demographic determinants of mental health.

Duration of stay at the hospital and likelihood of getting social support show that patients with a longer stay (above 4 years) were less likely to receive the support from the family and significant others. Long treatment cost becomes a problem and some patients are very far from home, which made it very difficult to receive visitors from their social network, which will result in support (Mc Corkle, Rogers, Dunn, Layass & Wan, 2008). Again, McCorkle et al., (2008) asserted that the importance of social networks in providing social support at the time of psychological crisis is very important to the healing of patients. It will be difficult for individuals to reintegrate into community after hospitalization

(McCorkle et al., 2008). This is because the friends of network have been broken and sometimes forgotten.

Church attendance could also draw more close friends for patients and could lead to having stronger ties. From the results, it suggests that patients who frequently attend church were more likely to have more close friends, have group members as visitors and receive relatives as well as talk to them. This confirms the assertion of Cohen (1988) that when individuals are in regulative psychological state, they are bound to experience increase neuroendocrine and cardiovascular responses, which suppresses immune function and interfere with performance of health behaviours. Krause and Ruxton (2002) found that attending church more regularly positively correlate with feeling that the congregation is more cohesive and with feeling closer to God. For instance, older persons who report feeling closer to God are more optimistic and have better self-reported health outcomes. Ellison and George (1994) stated that the influence of social ties in church could be a possible factor since people who involve more in their faith tend to get more support compared to individuals who are less involved.

Finally, church attendance gives rise to being in social relationship, which relates strongly to the direct effects (Cassel, 1976) of social support – causes variations in the dependent variable – in this case, mental health status – notwithstanding the maintenance or control of all other variables. Having enough social support because of frequency of church attendance could cause effect in the recovery process of the mentally challenged. This is because there is a beneficial effect (Lakey & Orehek, 2011) of social support. According to Uchino (2004), supportive interactions with others benefit immune endocrine and cardiovascular functions that reduces allostatic load that reflects wear and tear on the body due in parts to overwork in stress response.

On sources of social support, it was found that patients aged 40 and above were less likely to receive social support from the family, significant others and friends than those aged 20-29. This finding is consistent with Carstensen (1986), who posited that people maintain social connections with numerous others throughout life. However, during the latter part of adulthood, rates of social interaction begin to decline.

Another illustration by Antonucci, Fuhrer and Jackson (1990), suggested that aging tends to be associated with shrinkage of social network, both support receiving, and support giving found to decline as age increases. Simon, Chen and Dong (2014) have also confirmed this in earlier studies that draw on evidence that reliance on different social group change as one grows older. For instance, adolescents draw more on peer network compared to the older people. This could have accounted for the findings in addition to shrinkage of social support for the mentally challenged. Inadequate social support for patients who are aging could be a challenge in recovery from mental health problems since coping and resilient building is affected compared to patients aged 20-29 years.

Results on marital status and sources of social support both descriptive and inferential, suggest that patients who were married were more likely to receive social support than those who were single. For instance, higher proportion of patients who were married received social support than those who were single. These could be support from their spouses, which could cushion them to cope. Again, studies have shown that marital supports and stressors not only help to explain health differentials among married individuals, but also help to condition the marriage benefit and is even associated with metabolic syndrome (Whisman, Uebelacker & Settles, 2010). The findings also confirmed the work of House et al (1988) who posited that people who were married have more benefits in terms of health. This could be the reason why most patients who were married could receive social support such as, emotional social support and instrumental support than others. Again, the findings on patients who were divorced or separated resonates the work of Folkman (2001) that there are detrimental effects for people who are unfortunately widowed or those who have separated.

Berg and Upchurch (2007) corroborated this that the interactions between spouses are more frequent and intense than those with other members of the social network and provision of social support from spouses during illness is associated with better adjustment in patients. Burman and Margolin (1992) found that stress/social support hypothesis which is intimate relationships which is likely source of support as well as possible stressor could be a key driving force behind success related stories relating to good health in marriage.

Using a variety of health outcomes, research operating from this perspective have consistently shown that marital supports and stressors not only help to explain health differentials among married individuals but also, help to condition the marriage benefits. For instance, marital supports and stressors have been associated with metabolic syndrome (Whisman, Uebelacker, & Settles, 2010), blood pressure (Holt-Lunstad, Birmingham, & Jones, 2008), self-reported health (Umberson et al., 2006), and psychological distress (Whisman & Kaiser, 2008). The findings therefore could mean better adjustment among the mentally challenged found to receive more of the emotional and instrumental support.

Additionally the findings re-echo Durkheim's assertion of abnormal behaviour among those who were not with their spouses. Similarly, support from spouses could help patients cope and more resources for those in marital unions could promote adaptability and coping among mentally challenged.

It also found that patients who have attained tertiary level of education were more likely to receive social support from friends, family members and significants others. A review of population surveys in European countries by Lehtinen, Sohlman and Kovess-Masfety (2005) found that communities where there are higher occurrences of common mental disorders (depression and anxiety) are associated with low educational attainment, disadvantage in material and unemployment and that in older people, there was social isolation (WHO, 2013) which could still contribute to depression.

In addition, the social consequences of lack of education lead to a diminished opportunity for persons to access resources to improve their situation (Hussain, Creed & Tomenson, 2000). This could have a linkage on the mentally challenged whose level of education is low leading to low level of resources, including social capital which could affect immensely their social support, especially at hospitals or in their communities.

Results on employment suggest positive relationship between employment and sources of social support for patients. Patients who were employed could draw more support from friend, significant others and from family. They could get both emotional and tangible support as well as have varied sources compared to the unemployed. There is a strong linkage between education, employment and income. Patients employed could have an appreciable level of education or income, which could provide resources for them. Once more, they could employ the services of caregivers to take care for them that could lead to much better social support to help them adapt and cope better than those who are unemployed.

Work, according to Human Development Report (2015), apart from being a valuable supporter of mental health, gives structure and rhythm to daily lives and gives opportunity for satisfying relationships that could account for social support for patients who were employ. In addition, the Sustainable Development Goal 8, further recognised importance of work in which state parties directed to promote decent work for all (United Nations, 2015). Employment could also lead to income on which patients depend on even when on admission. These findings resonate with the findings of Jenkins et al., (2008) which stated that the association between low income and mental disorders accounted for by debt people had. They found that the more debt people had, the more likely they were to have some form of mental disorder. In addition, a review of population surveys in European countries found that higher frequencies of common mental disorders are associated with low educational attainment, material disadvantage.

Employment, equally in poor nature with no or short-term contracts and jobs with low rewards and control at work had harmful impact on mental health whiles job security and a sense of control at work are protective of good mental health (Anderson et al., 2011; Bambra, 2010). For instance, data analysed by European Union and countries over the period of 1970-2007 showed that every 1 percent increase in unemployment was associated with a 0.79 rise in suicide at ages younger than 65 years (Stuckler, Basu, Suhrcke Coutts, McKee, 2009). A related study by Kasl and Jone (2000) also showed evidence from a longitudinal study that unemployment is associated with an increase rate of depression.

There is a positive relationship between frequency of church attendance and sources of social support. Outpatients account relate to these findings where some of them find joy in prayers offered them by their evangelists or pastors. These support could be instrumental, emotional, informational support from the family, significant others and friends. In addition, patients who attend mosque or church more than four times in a month were more likely to receive social support from the family, friends and significant others compared to patients who attend church only once in a month. Pardini et al., (2000) found in a study of 237 recovering substance abusers that higher levels of religious faith and spirituality predicted a more optimistic life orientation, greater perceived social support, higher resilience to stress and lower levels of anxiety. In the interview of one of the outpatients, they get deeper consolation from the teachings of the Bible and draw on the encouragement from the leadership of the church not to give up.

For example, Underwood and Teresi, (2002) who conducted interview about the role spirituality played in the daily lives of people with mental health condition was realised that people reported being able to experience deep peace even in the midst of mental distress. Spirituality can enable people to step outside or beyond the mental distress and experience comfort and calm. Especially in the midst of crisis, particular kinds of spirituality can prove to be a powerful resource, which can be a real buffer against excessive mental distress and despair (Pargament, 1997).

Apart from Christianity, some other studies have corroborated earlier findings on religion and mental health. For instance, on Islam (Abu-Rayya, Abu-

Rayya & Khalil 2009), Judaism (Rosmarin et al., 2009) and Hinduism (Tarakeshwar Pargament & Mahoney, 2003) found that those who are religious have better indices of mental health. These indices could have been possible as posited by Dein (2006) to include positive cognitive appraisals, increased social support, healthy lifestyles (diet, less alcohol and drugs) and supportive relationships with God. Social relationship in church is an explanation factor for good mental health indices. These findings are consistent with the statement of Ellison and George (1994) that the influence of social ties in church could be a possible factor since people who involve more in their faith they tend to get more support compared to individuals who are less involved.

The findings on social support has a linkage with the stress-buffering hypothesis, which is indirect effect of social support on health. Social support is link to physical and psychiatric illnesses through multiple "mediating" variables (socio demographic characteristics, social influence, access to services and information) that are associated with biological parameters and neuro-endocrine response. Cobb (1976) emphasised that the effect of social support as a stress buffer shown in studies that the existence and quality or inversely absence of social relationships play a role in wellbeing throughout lifetimes.

Summary

The chapter looks at types of social support and sources among the mentally challenged in the Psychiatric hospital of Ghana. Mentally challenged in the Psychiatric hospitals do receive emotional, instrumental and informational support. However, emotional and instrumental support were very important to the mentally challenged since they coped with them. Again, structural social support show that those who were married have higher level of education and those who were employ were more likely to benefit from friends than patients who were above 40 years. Again, those who were above 40 years were less likely to receive group members as visitors. Finally, the sources of these social support show that significant others and family members were very important to the provision of social support to mentally challenged whilst social support from friends was on the low side.

CHAPTER SEVEN

ASSESSMENT OF SOCIAL SUPPORT AMONG MENTALLY CHALLENGED PATIENTS

Introduction

This chapter presents results on assessment of social support in which both negative and positive aspects of social support were analysed by socio-demographic characteristics of patients. Moreover, the likelihood of interpreting social support received as positive or negative is also estimated by the use of binary logistics regression. The findings, thus using both descriptive and inferential information are discussed in relation with the literature review and the framework chosen for the work.

Assessment of Social Support from Parents and Significant Others

Results on assessment of social support, thus whether patients were dissatisfied, unpredictable, and conflicted with thoughts or not with parents and significant others who provided social support is presented in Table 17. Generally, on social support received, about 49 percent of the sample were dissatisfied, 53 percent were conflicted and equal proportions (53 percent) could not predict social support from parents and significant others.

On age, 64 percent of patients aged 20-29 were dissatisfied with social support from parents and significant others. Similarly, about 61 percent of the patients aged 40 and above were dissatisfied as well as the same proportion (61 percent) of patients were in conflict with the social support of parents and significant others.

Assessment by marital background and social support indicates that two-thirds (78 percent) of patients who were single could not predict provision of social support by parents and significant others. Again, the results also suggest that 64 percent of patients, who were divorced, were also in conflict with social support provided by parents.

Patients' educational status also indicates that nearly two-third (69 percent) of patients with basic education were dissatisfied with social support. Similarly, the same patients' category of about 66 percent could not predict social support from parents and significant others.

Gender background of patients and effects of social support (Table 17) show that 68 percent of male patients were dissatisfied with social support from parents than female patients (51 percent) ($X^2 = 5.328$, $p<0.041$). Equally, higher proportion (65 percent) of male patients could not predict about social support from parents and significant others. Results on family suggest that more than two-thirds (74 percent) of patients from extended family were satisfied with social support from parents and significant others. However, 66 percent of the same category of patients were conflicted with social support from parents and significant others.

Additionally, proportion of patients from households with 6-9 members (19.7 percent) reported having negative interactions and social support and by inference, about 80 percent of patients in these households were satisfied with social support from parents and significant others. In addition, about 85 percent of patients in these households did not have any conflict of social support from parents (X^2 =22.45 p<0.000).

Table 17: Assessment of Social Support from Parents and Significant Others by Socio-Demographic Characteristics

Variable			Parents	&	S.O		X^2 p-value
	Dissatisfied		Conflicted		Unpred.		
	Yes	No	Yes	No	Yes	No	
	48.6	51.4	53.1	46.9	53.2	47.1	
Age							0.498
20-29	63.8	36.2	57.4	42.6	56.7	43.3	0.782
30-39	59.6	40.4	55.0	45.0	51.9	48.1	
40+	61.1	38.9	61.1	38.9	50.0	50.0	
Marital							3.83
Single	36.2	63.8	39.7	60.3	77.6	22.4	0.298
Married	40.0	60.0	45.0	55.0	62.5	37.5	
Sep/Divorce	46.4	53.3	64.3	35.7	57.1	42.9	
Edu.							4.37
Basic	69.2	30.8	59.3	40.7	65.6	34.4	1.893
Secondary	62.4	37.6	58.4	41.6	49.5	50.5	
Tertiary	52.6	47.4	51.3	48.7	47.4	52.6	
Gender							5.32
Male	67.6	32.4	59.0	41.0	64.6	35.4	0.041
Female	51.3	48.8	43.0	57.0	43.4	56.6	
Emp.							4.00
Employed	67.5	32.5	61.0	39.0	58.8	41.2	0.08
Unemployed	53.6	46.4	50.0	50.0	47.3	52.7	
Family							13.34
Nuclear	47.9	52.1	48.6	51.4	57.5	42.5	0.000
Extended	26.2	73.8	66.4	33.6	31.4	68.6	
H.Hsize						54.1	22.5
1-5	48.1	51.9	53.2	46.8	54.8	45.2	0.000
6-9	19.7	80.3	15.5	84.5	23.9	76.1	
10+	31.6	68.4	55.3	44.7	55.3	44.7	
Duration							8.43
<1yr	50.5	49.5	46.4	53.6	51.0	49.0	0.040
1-3yr	37.7	62.3	56.5	43.5	47.8	52.2	
4+	26.8	73.2	68.0	32.0	62.9	37.1	

Source: Fieldwork (2017)

Finally, Table 17 presents duration of stay at the hospital and how patients interpret social support from parents and significant others. From the results, patients with more than 4 years stay at the hospital (68 percent) were conflicted with social support from parents and significant others. Equally, 63 percent of the similar category of patients could not predict about social support from parents and significant others (X^2= 8.4293, p<0.040).

Receiving Negative or Positive Support from Parents and Significant Others

It is observe that when two individuals are involved in a relationship, their agendas (Brooks & Dunkel, 2011) will not always align. As they depend on each other, there is also potential for conflict. This could be partners, children and parents or friends. Table 18 presents estimate results on patients being dissatisfied or not with social support from parents and significant others. On age, the result indicates that patients aged 30-39 were less likely to be dissatisfied with social support from parents and significant others (OR = -0.416, p<0.015) compared to patients aged 20-29 years. By implication, patients in this age category could see what ever support from parents and significant others as positive.

Furthermore, patients who had attained tertiary level of education were less likely to be dissatisfied with social support from parents and significant others (OR= -0.538) compared with patients who had attained basic education level. The result could suggest that patients in this category might see and interpret whatever support received to be positive. Similarly, male patients were more than two times likely to be dissatisfied with social support from parents and significant others (OR = 2.151, p<0.016) compared to the female patients.

Male patients in effect could interpret social support from parents and significant others to be negative than positive (Table 18).

Table 18: Logistic Regression Estimates of the Likelihood of being Dissatisfied with Social Support from Parents and Significant Others.

Variable	B	SE	Wald	Df	p-value	O.R	95% CI for EXB	
							L	U
Age			6.052	2	0.049			
20-29 Ref								
30-39	-0.877	0.360	5.938	1	0.015	0.416	0.205	0.842
40+	-0.44	0.747	0.37	1	0.556	0.644	0.149	
Marital			2.582	2	0.275			
Single Ref								
Married	0.088	0.489	0.032	1	0.857	1.092	0.419	2.847
Divorced	-0.785	0.542	2.096	1	0.148	0.456	0.158	1.320
Education			2.522	2	0.283			
Basic Ref								
Secondary	-0.243	0.368	0.437	1	0.508	0.784	0.381	1.613
Tertiary	-0.619	0.395	2.453	1	0.117	0.538	0.248	1.169
Gender								
Female Ref								
Male	0.766	0.319	5.752	1	0.016	2.151	1.150	4.023
Employment								
Unemp. Ref								
Employed	0.890	0.317	7.870	1	0.005	2.434	1.307	4.532
Hhsize.			8.348	2	0.015			
1-5 Ref								
6-9	1.350	0.468	8.326	1	0.004	3.857	1.542	9.649
10+	0.596	0.568	1.227	1	0.268	1.814	0.362	5.206
Duration			15.440	2	0.000			
<1 Ref								
1-3	0.774	0.370	4.370	1	0.037	2.168	1.049	4.023
4+	1.543	0.395	15.281	1	0.000	4.678	2.158	10.138
Constant	-1.034	0.441	5.511	1	0.019	0.355		

Source: Fieldwork (2017)

From Table 18, the results show that patients who were in employment before the admission were more than two times likely (41 percent) to be dissatisfied with social support from parents and significant others (OR = 2.434, p<0.005) compared to those who were unemployed. By implication, whatever social support provided by parents, is negative. Patients in household size of 6-9 members were likewise more than three times likely to be dissatisfied with social support provided by parents and significant others (OR= 3.857 p<0.004) compared to patients in a household of 1-5 members.

Finally, results from Table 18 suggest that patients who were on admission for four years and above were more than four times likely to be dissatisfied with social support from parents and significant others (OR= 4.678 p<0.000) compared to patients with less than 6 months stay at the hospital. This in addition indicate that patients with more years of stay at the hospitals could interpret whatever social support provided to be inappropriate and therefore see it to be negative.

Conflict with Social Support from Parents and Significant Others.

Table 19 presents results on whether patients have received conflictual social support from parents and significant others or not. The estimates show that patients who were divorced were less likely to be in conflicts with social support from parents and significant others (OR = -0.244, p<0.011) compared to patients who were single. Likewise, patients who were employed were more than two times likely to be in conflict with social support from parents and significant others (OR=2.151 p<0.015) compared to the unemployed. These patients were previously busy working, and the conditions have rendered them unemployed, and for these reasons, interpret whatever assistance given as negative.

Household size, and assessment of social support indicate that patients in a household of between 6-9 members were more than 7 times likely to be in conflict with whatever social support they had from parents and significant others (OR=7.211, p<0.000) compared to patients in household of more than 10 members as well as household of 1-5 members. Again, patients with more than 4 years stay on admission were more than 4 times likely to be conflicted with social support from parents and significant others than patients with less (OR=4.446 p<0.000) than six months stay at the hospital.

Table 19: Logistics Regression Estimates of Reciving Conflictual Social Support from Parents and Significant Others.

Variable	B	SE	Wald	Df	p-value	OR	95% CI for EXB	
							L	U
Age			1.263	2	0.443			
20-29 Ref								
30-39	-0.391	0.349	1.257	1	0.262	0.676	0.341	1.340
40+	0.135	0.763	0.031	1	0.859	1.145	0.257	5.102
Marital			6.522	2	0.038			
Single Ref.								
Married	-0.274	0.484	0.320	1	0.572	0.760	0.294	1.964
Divorced	-1.410	0.556	6.438	1	0.011	0.244	0.082	0.726
Education			1.467	2	0.480			
Basic Ref.								
Secondary	0.360	0.363	0.983	1	0.321	1.434	703	2.923
Tertiary	-0.016	0.392	0.002	1	0.967	0.984	0.456	2.122
Gender								
Female Ref								
Male	0.379	0.317	1.426	1	0.232	1.461	0.784	2.722
Employment								
Unemp. Ref								
Employed	0.766	0.314	5.938	1	0.015	2.151	1.162	3.981
Hhsize.			20.895	1	0.000			
1-5 Ref								
6-9	1.976	0.492	16.146	1	0.000	7.211	2.751	18.903
10+	-0.156	0.512	0.093	1	0.761	0.855	0.313	2.336
Duration			15.135	1	0.001			
<1 Ref								
1-3	0.469	0.372	1.590	1	0.207	1.598	0.771	3.311
4+	1.492	0.386	14.933	1	0.000	4.446	2.086	9.477
Constants	-1.319	0.445	8.803	1	0.003	0.267		

Source: Fieldwork (2017)

Assessment of Social Support from the Family and other Relatives

Table 20 assesses social support from patients' point of view and family members as well as other relatives. Overall, 58.4 percent of the sample were dissatisfied, 59 percent were conflicted and about 61 percent of the sample could not predict of social support from the family and other relatives.

Patients' educational background and effects of social support show that a large proportions of patients who had attained basic education were more dissatisfied (72.9 percent), more conflicted (67.3 percent), and more doubtful (66.3 percent) about social support from the family than their counterparts with tertiary education (dissatisfied, 49.1 percent, conflicted 50 percent and doubtful, 57 percent). It is realised that large proportions of patients with basic education reported to have received negative social support than positive from parents compared to patients with tertiary education.

Results on patients' gender background show that large proportion of male patients were dissatisfied and conflicted with social support compared to females. For example, average negative support from the family for males (64 percent) is higher compared to females which is 51.4 percent ($X^2 = 3.938$, $p<0.049$).

Types of family of patients indicate that a higher proportion of patients from extended family setting were dissatisfied (64 percent), conflicted (63 percent) and could not predict (68 percent) social support from the family. From Table 20, the results suggest that a higher proportion of patients from extended background could report negative social support from the extended family than patients from nuclear family.

Household size and social support from relatives and family members among patients show that about 62 percent of patients from households with membership of 10 or more were dissatisfied with social support from family members and other relatives than patients from households of 1-5 members. Similarly, about two-thirds (71 percent) of patients from households of 10 or more members were conflicted about social support from the family and relatives compared to patients from a household of 1-5 members. It is realised from the results that the proportion of patients who reported negative support from households of 10 or more members were higher than the proportion of patients from a household of 1-5 members.

Finally, results on duration of stay in the hospital and effects of social support from the family and relatives are presented in Table 20. Six out of ten (62 percent) of patients with more than 4 years of stay at the hospital were dissatisfied about provision of social support from the family than patients from household of 1-5 members. Similarly, it was found that patients with the same duration of stay (about 64 percent) were additionally conflicted and could interpret whatever social support provided by the family to be negative than positive.

Table 20: Assessment of Social Support from Family and Other Relatives

Demographic	Family Members/Relatives (%)							
	Dissatisfied		Conflicted		Unpredictable			
	Yes	No	Yes	No	Yes	No	X^2	P-v.
	58.4	41.7	58.6	41.5	61.8	38.7		
Age							3.887	0.153
20-29	64.1	35.9	61.9	38.1	66.9	33.1		
30-39	51.3	48.7	51.2	48.8	54.5	45.5		
40+	63.0	37.0	66.7	33.3	66.7	33.3		
Marital							2.215	0.386
Single	62.1	37.9	59.7	40.3	65.4	34.6		
Married	57.6	42.4	56.5	43.5	54.3	45.7		
Sep/Divorce	47.1	52.9	53.1	46.9	54.0	46.0		
Education							5.158	0.163
Basic	72.9	27.1	67.3	32.7	66.3	33.7		
Secondary	53.6	46.4	55.4	44.6	60.8	39.2		
Tertiary	49.1	50.9	50.0	50.0	57.0	43.0		
Gender							3.938	0.049
Male	64.3	35.7	63.3	36.7	64.6	35.4		
Female	48.5	51.5	49.1	50.9	56.6	43.4		
Family							2.909	0.060
Nuclear	52.7	47.3	53.8	46.2	56.7	43.3		
Extended	64.4	35.6	63.1	36.9	67.7	32.3		
HHsize							8.759	0.074
1-5	53.0	47	50.0	50.0	54.0	46.0		
6-9	67.3	32.7	69.2	30.8	76.9	23.1		
10+	62.1	37.9	70.5	29.5	65.9	34.1		
Duration							1.109	0.59
<1yr	58.9	41.1	55.3	44.7	58.9	41.1		
1-3	54.3	45.7	53.6	46.4	62.3	45.7		
4+	62.3	37.7	62.7	37.3	64.4	37.7		

Source: Fieldwork (2017)

Conflictual Social Support from the Family

Table 21 presents results on the likelihood of receiving conflictual social support from the family.

Table 21: Logistics Regression Estimates on the Likelihood of being Conflicted with Social Support from the Family

Variable	B	SE	Wald	Df	p-v	OR	95% CIfor EXB	
							L	U
Age			1.628	2	0.433			
20-29 Ref								
30-39	-0.729	0.340	4.588	1	0.032	0.483	0.248	0.940
40+	0.232	0.532	0.191	1	0.662	1.262	0.445	3.580
Marital			1.081	2	0.583			
Single Ref.								
Married	0.008	0.448	0.000	1	0.987	1.008	0.419	2.425
Divorced	-0.411	0.427	0.930	1	0.335	0.663	0.287	1.530
Education			4.292	2	0.117			
Basic Ref.								
Secondary	-0.617	0.337	3.340	1	0.068	0.540	0.279	1.046
Tertiary	-0.656	0.362	3.292	1	0.070	0.519	0.255	1.054
Gender								
Female Ref								
Male	0.858	0.286	8.985	1	0.003	2.359	1.346	4.135
Employment								
Unemp. Ref								
Employed	0.667	0.294	5.165	1	0.023	1.949	1.096	3.465
Hhsize.			7.865	2	0.020			
1-5 Ref.								
6-9	0.978	0.390	6.289	1	0.012	2.660	1.238	5.713
10+	1.175	0.501	5.509	1	0.019	3.238	1.214	8.636
Constant	-0.277	0.419	0.436	1	0.509	0.758		

Source: Fieldwork (2017)

From the analysis, patients aged 30-39 were less likely to be in conflict with social support received from the family and other relatives (OR= -0.483, p<0.032) than patients age 40 and above as well as patients 20-29 years. In addition, the results suggest that patients who have attained tertiary level of education were less likely to have mixed feelings with social support from the family and relatives (OR = - 0.519) than the single.

Gender background of patients reveals that male patients were two times more likely to be conflicted with social support from the family and relatives (OR = 2.359, p<0.003) compared to female patients. Similarly, patients who were employ were more likely to receive and conflict with social support from the family and relatives than patients who were unemployed. Finally, results on household size (Table 21) indicate that patients in household of 10 or more were more than three times likely to be conflicted with social support from the family and relatives (OR=3.238, p<0.019) than patients in a household of 1-5 members.

Discussion

The estimate results on age and effects of social support suggest that patients aged 30-39 years were less likely to be dissatisfied, conflicted with social support from parents/ significant others and the family. However, it find that patients aged 40 and above, see social support from parents and family to be negative. In addition, from the descriptive results, patients aged 20-29 reported having had negative social support from parents and family members.

The findings could mean that patients age 20-29 could be dependent on their parents and although, parents provide support and other forms of care, these social supports could involve controls that might be misinterpreted to be negative. Further, providing support for these groups of patients by parents and significant others could be obligatory which at times' come with controls that is inappropriate hence; there could be conflict or dissatisfaction about the support. These findings resonated with Uchino (2004) and Cohen (2004) who see certain aspects of social support to be detrimental which leads to negative consequences.

Once more, they found that obligatory social ties could produce stressful social demands.

In addition, Thoits (2011) also suggested that support may initially been as a source of distress, but in later life could be seen as a good preventive measure to improve health. For instance, parents could prevent patients who were alcoholic or smoking which could be resisted hence conflict. Besides, negative support for patients aged 40 and above could mean shrinkage in the social support in the first place and according to Carstensen (1991), aging tends to be associated with lower support. At this age onwards, most spouses, of patients who are married are to provide support. In a situation where spouses are not available as results of death, social support from family and relatives could be a problem. As noted by Gupta and Korte (1994), an absence of a spouse in old age renders family support irrelevant hence the findings. This could affect coping and resilience among mentally challenged and this delays healing.

The estimates show that generally, both patients who were married were less likely to be in conflict with social support, from parents and family members than the single. Descriptive results also show similar trend. According to Uchino et al., (2001) in the positivity and negativity framework, high positivity and low negativity in relationship and social support could be social network ties that may perhaps be sources of high social support. These support could be embedded in strong network ties hence the findings.

According to Berg and Upchurch (2007), interactions between spouses are more frequent and intense than those with other members. This could explain the reason why married patients could receive more positive support from parents and significant others who might be spouses and friends compared to other family members. In another vein, widowed, separated and the divorced may possibly have children who perhaps be a responsibility of family members hence, the level of positive support compared to those who were married.

On the other hand, the results on the patients who have never married suggest that a higher proportion of patients who were single reported more negative social support than positive support. According to Lourel et al. (2013), negative social support may be seen to be inappropriate or absent and inadequate. Since the single could not depend on spousal support, it possibly might explain the reason why patients who were never married or single could report more negative support than positive support. Additionally, feeling of isolation and loneliness could become more visible among those who are not married and support at that level might be misinterpreted, hence the findings. Moreover, most studies (Folkman, 2001; Whisman, Uebelacker & Settles, 2010) have seen married couples to benefit from social support than the single and this could be the reason why the single receive more negative support than positive support in comparison with those who are married.

Another concept relevant to this finding is the theory of optimal matching hypothesis (Cutrona & Russel, 1990) which posited that stress protection occurs only when there is a match between the needs elicited by the stressful events and the functions of social support that are perceived to be available. Perhaps whatever types of social support the single might receive might be inappropriate compared to those who are married or divorced. There could also be feeling of loneliness among the singles and source of support could be from the family, which might not meet what they expect.

The findings on employment status show that patients who were employed before admission were more likely to be dissatisfied, conflicted as well as doubt social support from parents, significant others and family members. These patients could see whatever support provided to be negative or inappropriate than positive.

This, in comparison with the unemployed, shows that the unemployed rather interpret social support as positive from parents than the employed. This could be for the reason of conflict with self-concept and social identity (Cruwys et al., 2014). The employed patients have been fully employed before the condition, which takes them away from work and what they used to do, which is lost because of the condition could be irritating. In this regard, whatever support might come, cannot be appropriate or even enough and this could affect their appreciation of such supports.

This lends credence to Human Development Report (2015) that "Work enables people to earn a livelihood and be economically secure. It is critical for equitable economic growth, poverty reduction and gender equality." Further, work is to allow people fully participate in society while affording them a sense of dignity and worth. Work is also a valuable supporter of our mental health. It gives structure and rhythm to our daily lives, it gives the possibility for self-fulfilment, it strengthens our self-esteem and it provides security and an opportunity for satisfying relationships (WHO, 2005).

On the other hand, the results on the patients who have never married suggest that a higher proportion of patients who were single reported more negative social support than positive support. According to Lourel et al. (2013), negative social support may be seen to be inappropriate or absent and inadequate.

Since the single could not depend on spousal support, it possibly might explain the reason why patients who were never married or single could report more negative support than positive support. Additionally, feeling of isolation and loneliness could become more visible among those who are not married and support at that level might be misinterpreted, hence the findings. Moreover, most studies (Folkman, 2001; Whisman, Uebelacker & Settles, 2010) have seen married couples to benefit from social support than the single and this could be the reason why the single receive more negative support than positive support in comparison with those who are married.

The estimates on educational level of patients show that patients with higher level of education were less likely to receive negative social support from the family, parents and significant others than those with basic education. From the descriptive report, there were half of them (50 percent) with tertiary educational level who reported having received positive social support from parents, significant others and family members. The same level of positive and negative support among patients according to Uchino et al. (2001) denotes network ties referred as ambivalent network that could be both sources of negativity and positivity of social relationship and support. With regard to the findings, it may be because of network members that support patients at the same time control them. The findings similarly suggest how compelling for instance, parents as well as significant others could be in providing social support for patients with higher educational status who could have been household heads before the sickness. Equal aspect of social support among patients with higher education from parents could also mean that patients might have other alternative sources of income since they could have more networks, social capital (Putnam, 1993) than those with basic education, hence the outcome of the kind of support received.

On gender, the logistics estimates show that male patients were more likely to received negative social support from parents, family members and significant others. In the descriptive analysis, females reported less negative support and receive more positive social support especially from parents and significant others than males. A number of related studies on gender differences in social support find women to receive more social support than males Simon, et al., 2014; Sexton et al., 2001). The argument is that females are involved in a lot of relationship and emotional closeness than males hence their ability to get more support as well as positive support than male.

Further, from the literature (Atefoe et al., 2014; Simon et al., 2014; McDowell & Serovich, 2007) noted that women have been seen to expressly seek for support than men. This results in having positive support for female patients than male patients who do not seek for support but provided with such supports, which might result in interpretation of such supports as inappropriate or negative.

Yet again, according to Taylor et al. (2000), women profit more when support is available. Interpretation of support could be inappropriate if it does not profit one and since women seek for support than men, mentally challenged females could seek for support that will benefit them than males. For instance, females could receive more visitors than their male counterparts, which might profit them more than their male.

The results on the family background additionally suggest that patients from nuclear family could receive more support that is positive and less negative support compared to patients from extended family background. This could be explain within the concept of network density being strong or weak (Cohen, 2004; Mattson & Hall, 2011). Analysis of Table 17 shows that parents and significant others could provide a higher positive support to mentally challenged patients than the family. These findings might be because strong networks are normally in the nuclear family where father, mother and other families are obligated to support each other.

Again, reciprocity (Berkman et al., 2000; Mattson & Hall, 2011) thus the degree of exchange of resources in this type of family could account for the support level and its effects. Social support will negatively be intense if there are loose ties in nuclear families with detrimental effects. This finding means that the network surrounding the nuclear family may be intense, obligatory and that support is appreciated, hence a higher outcome of the positive support although, there are negative supports as well. In the extended family system, the results suggest that there are high negativity and low positivity of social support among patients. This Uchino et al. (2001), referred to as socially aversive tie within the family.

It was also found that patients in a household of 6-9 members were more likely to receive negative social support from parents, significant others and family members than patients in a household of 1-5 members. However, the descriptive results show that (Table 17) a higher proportion of patients in household size of 6-9 members could receive positive social support from parents and significant others compared to patients in household sizes of 1-5 and 10 or more members. This could still have linkage with strong and obligatory ties of members in a family who are responsible and enjoy enormous support from each other. Network density, or how interconnected patients are with the parents and other significant others who may be spouses and friends, might be the reason why patients from these households' even though large household sizes, have members being responsible. The higher positive social support seen from parents and significant others could lend credence to the work of Mattson & Hall (2011), who proposed that strong network ties could lead to higher exchange of resources.

However, descriptive results show that, patients with household sizes of 1-5 members or more could receive more positive social support from the family members and relatives than those with household sizes of more than 10 members or more. This finding possibly could be explained in terms of attachment theory (Bowlby, 1980). Attachment could form a basis of one's relationship with members of the family which may well be a fertile ground for social support when one is in trouble for later life. Patients from these households could therefore have strong ties with the family members and relatives hence a higher level of positive support than the others.

The logistics estimates indicate that patients with longer stay at the hospital, thus more than four years were more likely to receive negative social support from parents, family and significant others than patients with less than 6 months stay. As patient's recovery delays, families get tired in providing social support. Once more, due to stigmatisation and discrimination, people get to know about the condition of the family member; hence, families shy away in providing care. This finding has a link with Hunt (2003) who argued that social inequalities driven by discrimination and marginalization of particular groups shape both the distribution of diseases and the course of health outcomes amongst those afflicted. As a result, the burden of illhealth is borne by vulnerable and marginalized groups in society.

Similarly, discrimination and stigma linked with particular health conditions, for example mental disabilities and diseases like HIV/AIDS, tend to reinforce existing social divisions and inequalities (Hunt, 2003). It is in light of this finding that the community centred approach by WHO (2013), Basic Needs (2014) and The Mental Health Act, (2012) is to allow mentally challenged patients interact with the community in order to reduce stigma. When stigma is reduce, appropriate care and social support provided for the mentally challenged.

Finally, another reason is in Diseth and Hoglend (2011). They found that individuals with mental illnesses who are receiving care in psychiatric institutions suffer greater human rights violations than individuals who are in conventional facilities. Those with less number of months stay in the hospitals constantly are in touch with their parents and family members. However, their family members forget those with longer stay at the hospital. Although the support at the hospital might not be the best for them, they had no choice than to contend with the support. Moreover, financial resource constraints (Roberts et al., 2013) which hamper feeding and basic care at the three facilities might also explain the negativity in support for patients who stay longer at the facilities.

Summary

The findings suggest that in providing social support, there could be both positive and negative aspect of it. Whiles patients see some of the social support to be positive, others also see it to be negative. In some cases, the positive aspect is higher than the negative aspect and similarly, the negative aspect of the social support is to be higher than the positive aspect.

CHAPTER EIGHT

CONSTRAINTS IN PROVIDING SOCIAL SUPPORT FOR THE MENTALLY CHALLENGED BY CAREGIVERS

Introduction

This chapter presents in-depth interview results on constraints that face both informal and formal caregivers in providing social support and care for the mentally challenged at home and in the psychiatric hospitals. In the case of informal caregivers, various burden of caregiving are label as constraints emanating from care in the family and the community. The institutional challenges are explore as constraints from the formal caregiving perspectives. The first part of this chapter focuses on informal caregiving while the second part, focuses on formal caregiving among personnel in the three psychiatric hospitals in Ghana.

Profile of key Informants

Ten informal caregivers interviewed across the three facilities as key informants: Out of which four were females and six were males. In terms of education, six of them had basic education while one of the caregivers had no formal education. Again, one of the caregivers had tertiary level of education whereas two of them had secondary education. On employment, eight of the caregivers were employed, thus either formally employed or in an informal sector. Five of them were also married and the rest were never married or divorced. These caregivers were uncles, siblings, parents and mostly family relations.

Analysis of the interview of caregivers show that informal caregiving involves a full time activity with the mentally challenged. It involves going to hospital with the patients for diagnosis, review and medication. Others involve seeking for support from the family members, bathing, cooking, directing, and protecting which takes caregivers' full time. In other situations, caregivers have to travel to shrines, prayer camps in search of spiritual solutions to the conditions of their loved ones. The theme on caregiving experience is presented in Table 22.

Table 22: Theme on Constraints in Caregiving

Themes	
Constraints	• Financial constraints in buying drugs, commuting etc • Poor Health of the caregivers • Social/religious constraints • Constraints of time (bathing, eating, medication) • Discrimination and stigma • Constraints in seeking for support by patients

Source: Fieldwork (2017)

Major Constraints

The major constraints are financial constraints, poor health of caregivers, social and religious constraints and constraints of time.

Financial Constraints

Caregivers have generally mentioned financial constraints across the three facilities. A 33-year-old Male who is a Taxi Driver and whose brother is suffering from Disorders of Adult personality (F60-F69) had constraints in taking care of his brother and reported that:

''Issues with money and my contacts are down. I cannot stay with him in compound house so I have to look for another place for him, which involves money. Sometimes I have to stay with him for a month without work and when we alternate the care, it is then that I will also work. I am worried I think a lot my other siblings are worried all because of financial challenges'' (A 33-year-old Male Taxi Driver).

Similarly, 20-year-old caregiver who is a dropout of Senior High School had financial constraints as results of caring for her father who is suffering from schizophrenia. She reports:

"I could not get money for school because my father is having this condition. He is not working so it is difficult to come by money. My brother is also not having money. The little he has we use it in buying drugs. I have been thinking and could not complete my school. No money we have to borrow sometimes and when my brother is paid then we pay back. The medicines are expensive too". (A 20-year-old caregiver).

In addition, 75-year-old female who had no formal education and engaged in charcoal business has been caring for the son with Schizophrenia and Delusional Disorders (F20-F29) for 6 years. She said:

"I have to look for money and bring my son hear. Even though he does not want to come, I have to force him to come for the check-up. I have been thinking a lot

look at my age if I die now who will look after him this is my son who is in university before the sickness. Sometimes we have been booked for review because of money I cannot go to the review with him. I do not get support from any place just from my little charcoal business. The medicines are expensive as well and we don't have money to buy the drugs" (A 75-year-old female caregiver).

A 50-year-old female trader could not come to hospital regularly for a review because of financial challenges. She said:

"It was the Ghana Police Service in my area that directs us to the hospital and when the medicine was given it seems okay, but because of distance and money, we have not been coming as often and the sickness is back again. My main problem is money for transportation to the facility because of that, I leave my daughter and come alone for the medicine for her. I am a trader and I have to close down my shop and come to the hospital" (A 50-year old caregiver).

In addition, a 35-year-old male who is Senior High School graduate and cocoa farmer as well as a trader has been looking after the nephew for 3 years with a Bipolar Disorder (F30-F39) complained about how caring for the nephew affects his work and business. He said:

"We have to use our building for loan of 3,000 Ghana cedis to be able to get him to hospital and get the drugs that have been prescribed. Sometimes also, we depend on our cocoa and this year (referring to 2017), the cocoa is not good but we have to borrow in advance to be able to take care of him. When you seek support and they realise is for sickness, most people do not want to give you, but if it is for business you can be provided" (A 35-year-old Male caregiver).

Poor Health of Caregivers

Some of the caregivers reported physical health conditions such as swollen legs. For instance, a 30-year-old employed supports her parents in taking care of her brother diagnosed of a mental condition. She said:

"I have swollen legs because of walking several distance to take care of my brother. The journey to the hospital is too far and I cannot abandon my brother. I have to visit him and provide food. I get tired, but I have to help. It is sad to bring a patient and leave them they need love and emotional support. When they know that someone loves them they get assurance that they are cared for and these things will help them to recover although it is difficult" (A 30-year-old female caregiver).

Similarly, others reported psychological health problems because of thinking about the situation as espoused by a 65-year-old cocoa farmer who takes care of his daughter of this condition. He recounted that:

"Because of my daughter's condition, I was diagnosed of having high blood pressure and I think a lot especially, when I look at how she behaves violently. I grew lean because we cannot eat, but we hope all will be fine" (A 65-year-old Male Caregiver).

Other caregivers are emotionally disturbed. The words of a 35-year old employed who takes care of the mother typified this:

"I cannot sleep at night because of my mother's conditions. I become tired and I am the only person taking care of my mother. My friends said I am reserve because I am always in haste to go to the house after work to take care of my mother and truly I feel I am a lone" (A 35-year-old Male caregiver).

In similar vein, a 39-year-old male JHS graduate who is a Dressmaker has been taking care of the mother with Neurotic Stress related condition (F40-F48) since 2002. He lamented:

"I do not have friends I am alone as a results of my mother's condition. Taking care of my mother has given me stress I think, but I have to continue" (A 39-year old Male Dress maker).

Social and Religious Constraints

There were social and religious constraints confronting caregivers in that the belief of causes of mental health illness delays recovery and worsens the problems. Again, some caregivers reported they could not work because of caring activities and some of them experienced fragile relationship and marital problems.

In the words of a 50-year old trader, they have been seeking for spiritual support for their daughter's sickness but to no avail. They have roamed to far places in search of spiritual support. She said:

"We have tried all means for the past 12 years. Initially, we believe the sickness came about as results of spiritual worms and so we visited prayer camps and consulted spiritualist all to no avail. We have done rituals and sacrifices but the problem is still there" (A 50-year old Trader).

Similarly, taking care of one's family member from the interview affects relationship and even negates marriage plans as espoused by a 36-year-old caregiver as:

"In terms of my relationship, I wanted to marry a lady before my brother's condition. Now my brother is staying with me and I plan that when he is okay then he will leave. This, I have discussed with my fiancée, but she is not happy

about it and it is as if she is finding problems with me and she started delaying the marriage. She confesses that my brothers staying with me is not comfortable to her so she does not want the marriage to proceed" (A 36-year old male caregiver).

A 35 five-year-old female caregiver who has been taking care of her mother for some time now had relationship problems, she intimated:

*"Sometimes I schedule to meet my fiancée, but there will be an emergency at home to take care of my mom. This sometime leads to cancellation of our meeting or not having any quality time together" (*A 35-year-old female caregiver).

A 65-year-old male caregiver had his farm destroyed because of taking care of his daughter. He remarked:

"My farm got destroyed because of caring for my daughter all of us came to the hospital to get her better. I am a cocoa and tomatoes farmer but because of the time spent at the hospital the farm got bushy and most of the crops were destroyed and we suffered financially as a family" (A 65-year-old male caregiver).

Constraints of Time

Time for work have effects on caregivers to the point of losing their jobs. A caregiver pointed out that:

*"I spend time with my mother help her to take her drugs, take her to see doctor three times in a week, help her bath. My challenge is that I have asked permission severally at work and my boss cannot take it anymore" (*A 35-year-old female Caregiver).

A male caregiver who is disturbed by the time constraints recounted that:

"I spend time with him at this hospital and this is affecting my work. I have been thinking a lot because I have to leave my work and take care of him. I have to be at work but I am here for review with him. Getting work these days is difficult and leaving work to care for my nephew is difficult but I have to try" (A 35-year-old Male Caregiver).

Likewise, a 30-year-old female who is unemployed, but takes care of the father with mental condition has this to say on time constraints:

"The delay when we come for review is too much. We spend the whole day here to see the Doctor. I stay with him in the house, cook for him, wash his cloths, help him bath and monitor him to take his medication. I watch TV with him. I do not get time for my personal life because I have to always be with him and for this I cannot go and work" (A 30-year-old female Caregiver).

Similarly, the time spent on caring activity is affecting relationships. A 36 year reported that:

"In terms of relationship, I wanted to marry a lady before my brother's condition. My brother is now staying with me when he is okay then he will leave. This, I have discussed with my fiancée, but she is not happy about it as it is delaying the marriage process. Now it is like she is finding problem with me and she does not want the marriage to come on" (A 36-year-old male caregiver).

Also, a female caregiver typified her relationship issues as:

"Taking care of my mother has taken all my time. You have to be with her and sometimes watch TV with her, you have to help her bath, eat and take her drugs on time. At times, my fiancée and I will plan to meet, but there will be emergency at home and so we could not meet it is having a serious effect on my relationship"

(A 35-year-old female Caregiver).

Discrimination and Stigma

Issues of discrimination and stigma were evident in the report of a male caregiver that:

"I use to stay in a compound house but when my brother's sickness started people of the house do not associate with us anymore. Sometimes when the sickness come, it becomes so violent that I had to call for assistance to take him to hospital. When my brother is using the bathroom or toilet facilities, he will delay and these things make other tenant not to have patience with us so I have to look for money and rent apartment" (A 36-year-old caregiver).

A 30-year old caregiver also said:

"Even though my brother is hospitalised, we do not disclose it to people. They know my brother is in school. And when he was discharge some time ago, he is always in the house we do not allow him to go out" (A 30-year-old female caregiver).

Constraints in Seeking for Support

Support seeking is by both caregivers and patients. However, the way it done sometimes gets caregivers worried. A 36-year old reported on the brother's behaviour when he sought support as:

"My brother is moody when he needs something sometimes he will come straight and said bro, I need this or that. If you could not provide what he wants he will shout and become aggressive and if it is not provided he will not eat and take his medicine"(A 36-year old Male).

Similarly, a 75-year old woman recounted about the treatment of the son sometimes when he needs support. She reports that:

"When my son needs something and you do not have it immediately he becomes violent and at times he will slapped me and neighbours will come in to restraint him. When it comes to going for review, he will not go he has to be force to go" (A 75-year old female caregiver).

Constraints of Formal Caregivers

These are professionals such as Psychiatrics, Doctors, Nurses, Pharmacist, and others. Government pay these professionals for services rendered to clients. In these institutions, certain fundamental and scientific regulations followed in admission, diagnoses and treatments of clients. Formal caregivers who granted the interview were ten. These respondents were facility personnel who work as Psychiatric Nurses, Pharmacists, Community Psychiatric Nurses (CPNs) Psychiatrics and Administrators. They have considerable years of working experience ranging between 5 to 25 years across the facilities. Theme presented in Table 23.

Table 23: Theme on Constraints of Providing Care to Patients

Themes	
Constraints	• Insufficient funds for care of the patients and running the facilities • Non-availability of some drugs (psychotropic) • Security challenges and danger especially with aggressive patients at the ward • Family care givers ran away from their patients and give wrong names and home addresses • Cultural/religious constraints

Source: Fieldwork (2017)

Constraints

The constraints are insufficient funds and drugs, security challenges, family neglect and cultural/religious constraints.

Insufficient funds and drugs

An Assistant Administrator at one of the facilities has this to say on the insufficient funds and its effects on drug procurement at the hospital:

"Logistics and simple handy materials are not available for easy care. Some basic equipment's that could take care of patients are not there. Money to run the hospital is the biggest issue. It is pathetic government funds are inadequate and delays. This affects procurement of essential drugs especially psychotropic for patients so most of the patients have to buy these drugs, which are expensive. We try our best but owe our suppliers and they are always on us for their money. It was as results of the funds that you can hear some facilities are embarking upon decongestion exercise" (A Male Assistant Administrator with 13 years of working experience).

A Nursing Officer for 5 years working with mentally challenged patients complained about the financial situations at the facility that made them work with difficulty and reported that:

"Basically in Ghana, treatment of mental health is free and it is supposed to be free. This made all the psychiatric facilities not generating anything for running the hospital and for the government. As such, government finds it difficult to provide the funds for the facilities which affect the feeding of the patients and lead to poor feeding. This also affects treatment of patients because it is difficult for patients to get free drugs and most patients are not able to buy the drugs. Because of stigma, the society is also not supporting the hospital as expected.

We create a free system of visitation from the family and society in order to support patients and the hospital, but only few people do come this is because of stigma. Simple OPD logistics to check and assess patients is difficult to come by" (A female Nursing Officer).

A Principal Pharmacy Technologist with 10 years of working experience at one of the psychiatric facilities said the drugs are expensive it is affecting recovery. In the view of this officer:

"The Government is no more supplying drugs to the facility. We buy drugs from open market; hence, the drugs are very expensive which patients cannot afford. Most patients are not recovering in the wards because unavailability of specific medications in the facility's pharmacy. Those that should be available are very expensive and most of the patients cannot afford"

(A Male Principal Pharmacy Technologist of 10 years' experience).

A female Psychiatric Nurse in-charge for 15 years illustrates the constraints facing them in care delivery as:

"Sometimes caregivers do not understand the symptoms of drugs administered to patients and when patients get drowsy and weak they do not understand why they should feel that way. There are also limited drugs because sometimes the drugs are not in the country and when you admit aggressive patients it is very difficult"

(A female Psychiatric Nurse In-Charge, with 15 years of experience).

Family Neglect

One of the constraints also facing the facilities is loss of contact tracing. Most family members bring their patients and run away making most patients unable to re-integrate with their family members. This poses many challenges, especially care at the facilities. A Psychiatric Nursing Officer with 11 years of working experience said:

"Some family members intentionally come with their patients and run away from the patients with excuse of taking few belongings for the patients. We also realise that most of them give us wrong names and wrong home and telephone lines. For over 10 years we could not traced them and so the patients become vagrant and the Government have to look after them and this creates congestions at the ward" (A female Psychiatric Nursing Officer with 11 years of working experience).

The Re-engaged Enrolled Nurse said similar findings:

"Some of the family members are from far places such as Kumasi, Northern region and even sometimes from Togo. Because of distance and money some of them find it difficult to come and eventually they abandon them on us" (Re-engaged Enrolled Nurse).

Lack of Security at the Facilities

There have also been security challenges at the ward across the three hospitals and presented in all the interviews of the facility personnel in this way:

"Some facility personnel especially, we the nurses get hurt by aggressive patients and some of the patients are danger to themselves and fellow patients because there are no securities in the ward couple with inadequate psychotropic drugs. You were witness to the incidence this morning (referring to an aggressive patient who head bat a nurse with blood oozing from her nose in an attempt to restrain the patients brought for a review by the family). I have been hurt many times and this is even affecting my left eye and ear. Sometimes when patients get relapse and there is no security, it is very dangerous and could be

fatal at times. The most worrying of all is that mental health workers are not on risk allowance"

(Re-engaged Enrolled Nurse).

Similarly, a Community Psychiatric Nurse (CPN) said:

"We the staff are the security. There is no security, sometimes patients run out and casual labourers had to help. When there are aggressive patients, we call for support from other wards and even at the main gate we do not have security"

(Community Psychiatric Nurse).

Culture and Religious Constraints

There are cultural and gender issues which hinder care and recovery and sometimes contribute to relapse of cases among mentally challenged. There are patients who do not take drugs because they are advice by their priests and religious leaders not to take drugs. Male or female patients do not want either of the opposite sex nurses to attend to them because it forbidden in their culture. Some patients also believe the cause of their illness is spiritual.

According to a Pharmacy Technologist, some religious beliefs affect negatively, patients' recovery. He expressed this as:

"Some patients reject the prescribed drugs because their spiritual leader told them not to take any drugs. This leads to a greater part of relapse of cases among mentally challenged. Some also consult spiritualist who prepare concoctions for them and as such, they reject our medicines this can only leads to complication of cases" (A male Pharmacy Technologist).

According to a female Psychiatric Nurse, the pattern of visit could have cultural and gender dimension by suggesting that:

"Visit is frequent when a person is their breadwinner. When patients are at acute ward visit is frequent but at chronic ward visit reduces. Also, females receive more visitors from the family than the male counterparts"

(A female Psychiatric Nurse).

Similarly, a male Assistant Administrator is of the view that:

*"Some patients because of their cultural and religious values they reject to be attended to by the opposite sex. Male patients refuse to be seen by females whiles females also do the same" (*A male Assistant Administrator).

Discussion

Financial constraints were evident in the interview of the caregivers. There were financial challenges in bringing the patients to hospital, buying drugs and provision of food and everyday care activities that comes with cost. Some caregivers have to borrow or sell their belongings in order to get money and send their patients to the hospital. Others could not buy drugs because of money and some of the caregivers could not continue with the treatment as results of financial challenges coupled with buying of drugs, which are expensive. This finding is consistent with the work of Malhotra (2016) who observed the constraints of care as negative consequences for parties and thus caregivers. It also finds that burden with its related problems like economic issues for instance, are key areas that adversely affect caregivers. These financial issues could affect quality of care, which can lead to relapse of cases in patients.

Apart from 'vagrant patients', most mentally ill admitted were outpatients, which compel family members to commute to these facilities for review. Similarly, the drugs that are supposed to be free are not available, but expensive at private institutions, which are prescribe for caregivers to purchase at a high cost. Again, since government funds are not available for use by these institutions, there are components of admission fees that are charged which is burdensome to the caregiver. It is infer that the inability of government to release funds to the mental hospitals is directly translating to some financial constraints for caregivers (White-Means & Rubin, 2004).

In addition, caring is a full time informal activity and unpaid job identified by Malhotra (2016) as well as Bowers (1987) who described it to be anticipatory, preventive, supervisory, instrumental and protective. These activities prevent many caregivers to concentrate on their full time work. Some of the caregivers have to abandon their work to care for their family members, which could also worsen the already financial difficulties in caring. The financial burden, which could have linkage on time, is described as being objective burden, which confronts families and leads to negative impact on their own physical health (Malhotra 2016).

The financial challenges also affect some households negatively. Some of the caregivers could not continue their education because there is no money to continue. The finding suggests that most caregivers could either not continue with their education or the caregiving has affected resources for the household such that, they are unable to continue with their education (Malhotra, 2016). Some of them also report low work output because of time spent in caring activities that consequently leads to financial challenges (Faden et al., 1987).

Analysis of caregiver's response also suggests that there was physical health, psychological and social problems as results of caring for their family members. Some caregivers reported developing blood pressure and heart problems because of thinking and having sleepless nights. Some of the caregivers also have their legs swollen all in an attempt to care. These findings have various linkages in the literature. Caregiving affects almost all areas of caregivers' life such as physical, psychological, economical, emotional and other functional health areas. This affects the caregiver negatively (Etters, Gooddall & Harrisson, 2008; Parks & Novielli, 2000). A caregiver who, not supported by the family could develop such problems and in some cases, die because of ill health as well as the psychological aspect. Research by Cochrane, Goering and Rogers (1997) in Canada for instance, revealed that caregivers have higher rates of emotional and anxiety disorders, and are twice as likely as non-caregivers to use mental health services for their own problems.

This physical and psychological as well as social challenges of giving care confirms what Malhotra (2016) stated as subjective burden which is described as the psychological reactions which relate to experiences such as feeling of loss, sadness, anxiety and embarrassment in social situations, stress of coping with disturbing behaviours and frustrations caused by changing relationships (Hansson, & Ostman, 2004). Most caregivers are embarrassed through social stigma and discrimination and this affects support seeking and being supported (Fournier, 2011).

From the results, most caregivers complain about the effect of caregiving on their marriage, relationships with friends at work and even their leisure life (Ostman & Hansson, 2004). A caregiving activity is multidimensional and does have complications at certain times. In addition, care recipients are isolated; the fear that the condition will relapse and get to complications made a lot of caregivers closely monitor their family members, hence almost all the time is spent on this activity which could destroyed one's marital life and relationship with others (Ostman & Hansson, 2004). Moreover, as a result of stigma and discrimination as narrated by caregivers in the interview, most caregivers conceal the situation from friends and even other family members hence, do not get assistance easily to break from the caregiving activity and for that reason, there is no time for leisure (Tawiah, Adongo & Aikings, 2015).

The findings on time relate to a number of studies. For instance, in a study of 362 caregivers of someone with schizophrenia by Stuart (2005) 65 percent of the caregivers indicated that they rarely or never had enough time off from caregiving to pursue their own activities. This resonates what one caregiver said, that she sends the mother for a review three times in a week. While at work her mind is at home and as soon as they close from work, she is in hurry to go home. This condition made her friends label her unfriendly because she does not have time for them.

Time constraints in caregiving of mentally challenged could prevent spouses of having time for each other and conjugal roles that come with marriage hence quality of relationship is affected which is transferred onto the marital relationship. Berry's work with family members signaled that family members tend to spend a considerable amount of time in caregiving roles. For instance, families of people with schizophrenia in the UK spend an average of 20 hours per week, the equivalent of a part-time job, in a caregiving capacity (Berry, 1997). This finding certainly means that the time for other activities such as leisure and time for a partner could affect marriage, relationships and in some cases, could lead to divorce.

As presented in the results, there are institutional constraints that confront formal caregivers in providing care for the mentally challenged at the three psychiatric hospitals of Ghana. However, facility personnel depend on government resources to provide care and support for the mentally challenged. Insufficient funds and drugs have been a main problem. This has transferable effect on major areas of mental health delivery. Formal caregivers complain about increasing cost of care especially the drugs, which are leading to relapse of cases. For instance, Robert et al., (2013) maintained that the cost of drugs in Ghana is more expensive than in other neighbouring countries. Additionally, access to medication is very critical in providing mental health care and an important human right issue to be upheld (Robert et al., 2013). It also adds that intermittent supply of medication could be dangerous for African countries involved. One could draw lessons that sudden stoppage of medication could lead to relapse of mental illness and worsen the long effort both formal and informal caregivers made in the recovering process of patients (Robert et al., 2013).

The finding on insufficient funding and drugs suggests that government finds it difficult to release funds for the three psychiatric hospitals, which may lead to poor care and indebtedness of the three psychiatric institutions to suppliers which results in poor feeding of patients. The effect of inadequate funding has led to a massive decongestion exercise where inpatients are allow to be at community setting with major implications for the community. For example, Appiah (2016) reported that between 2012 and 2015, psychiatric hospitals in Ghana owed creditors to the tune of 13 million Ghana cedis and this debt was because of purchase of medicines, food, facilities maintenance and others.

This finding also, related to many studies including (Agyapong & Mantey, 2011; Fournier, 2011; Basic Needs, 2014; Robert et al., 2013; Tawiah, Adongo & Aikings, 2015) that the concept of mental health and well-being of Ghanaians have somehow been neglected leading to poor treatment. For instance, an assessment of mental health policy in Ghana, South Africa, Uganda and Zambia by Faydi, et al., (2011) discussed the six gaps that could influence on the policies. Effects on countries' mental health systems include: lack of internal consistency of structure and content of policies; superficiality of key international concepts, lack of evidence on which to base policy directions, inadequate political support, poor integration of mental health policies within the overall national policy and legislative framework, and lack of financial specificity (Faydi, et al., 2011).

In addition, the World Health Organisation (2015) asserts that while the political will to invest in mental health continues to grow, it is still inadequate. For instance, public spending on mental health continues to be very low at 2 percent or less of the total health-care spending in lowest and middle-income countries or less than 2 percent per capita (WHO, 2015). Ghana, as a case in point, spends only 4.5 percent of total health budget on mental health and subverted organisations as at 2014 (MOH, 2014) which is inadequate to provide for essential drugs, food and other psychosocial care.

It is because of these difficulties that the formal caregivers, mainly the facility personnel complain of shortage and expensive drugs as well as poor feeding across the facilities. There are attempts to solve these challenges by passing the Mental Health Act, 846 2012. However, its implementation has not solved the problem. It is for this reason that Walker (2015), in his study on problems with the Act found that there were challenges to full implementation of the Act, especially financial resources that will delay its intended purpose.

The consequence of this is that most mental health problems go unnoticed in Ghana since there are delays in the approval of the Legislative Instrument by the Attorney General's Department that will make the Act operational.

The inadequate funding of these facilities also appear to be translating into inadequate logistics to work with at the facilities as suggested by the results. In the process, basic logistics for diagnoses at the OPD is even difficult to come by at certain times, which affect work. Meanwhile, the findings violate the standard set by the International Convention on Economic, Social and Cultural Rights (ICESCR). It proffered some steps, which highlight the creation of conditions, which assured to all medical services and medication. The Committee which monitors the ICESCR adopted general comments on the right to health at its 22nd session in 2000 (is General Comment 14) in a bid to provide guidance to countries on the meaning and requirements of implementing this right in recognition that, many people experience barriers to health and mental health services and care. The committee states that health care services require adequate funding to ensure that health facilities, goods, services and programmes as well as health care professionals and essential eradications are available in sufficient quantities. These challenges have effects on recovery process because if the patience do not take the drugs regularly for the reason that they are expensive and not available, patients get relapse and the cycle of treatment continues.

Family neglect and loss of contact tracing have also been one of the constraints formal caregivers face in providing support and care. Because of stigma and discrimination, most of the family members and informal caregivers give false contact to hospital officials who cannot trace the relatives of patients.

Some of the patients were outpatients and these patients are supposed to be coming for review but left at the hospital for care by the formal caregivers. As has already been illustrated, some family members proffered not able to stay in the compound house with their mentally ill family member and could not even take public transport with them hence the neglect. There are patients who have been in the facilities for more than 10 years and all contact tracing to meet the family prove futile. These come as additional costs to the hospitals especially at the time drugs are expensive and not easily available.

This finding of family neglect confirms the work of Hatzenbuehle and Link, (2014) that structural stigma comes from society and serves as a major barrier to wellbeing of the mentally ill. Calland, Ingraham, Martin, Marshall, Schulman, Stapleton, Barraco, (2012) also asserted that this level of stigma affects people in the area of housing and employment, which lead to interpersonal stigma. The stigma of commuting with a mentally challenged by some of the caregivers should lead to giving out false contact, which could make them damp their relatives at these hospitals to the detriment of the formal caregivers.

Again, the cost involved in caregiving as espoused by Malhotra (2016) could also compel caregivers to run away from their family members in this condition. The Mental Health Act 846 places heavy emphasis on community care rather than institutional care as in line with WHO Global Action Plan 2013-2020 (WHO, 2013). However, stigma and the value system of Ghanaian society could hamper the realisation of this dream as discrimination is on the rise and people in the community conceal any mental health related problems from each other. Family neglect becomes additional burden and cost to the government.

Lack of security situations at the ward and in the premises across the three psychiatric hospitals have been a challenge as realised in the findings. For instance, some of the formal caregivers give an account of an attack by violent and aggressive patients at the wards, which affect treatment and lead to injury of the staff (formal caregivers). From the results, there are 'lunatic criminals' and 'criminal lunatic' patients who were admitted for causing harm to others and danger to themselves hence absence of security at the ward could scare staff and their inability to provide care and support for aggressive patients. According to WHO (2012), the right to exercise legal capacity and the right to personal liberty and security of persons with disabilities have been used for assessing treatment of mentally challenged and situations where they are danger to themselves and to others violates their own right.

Additionally, this finding also corroborated the work of Fournier (2011) who studied two of the three psychiatric hospitals and found security lapses to be creating serious challenges for both the mentally ill and health workers. In Article 16 of the CRPD, it requires that all measures taken to protect and prevent all forms of exploitation, violence and abuse, including provision of protection services (United Nations, 2006). Once more, African Charter on Human and People's Right (1981) assert on regulation of people's right and elimination of all forms of abuses of the mentally challenged.

In addition, Diseth and Hoglend (2011) discussed mental health abuses of individuals in mental health settings who receive care. Similarly, the Constitution of Ghana (1992) and Patients Charter set standards for protection of patients and vulnerable. World Health Organisation's Constitution which is one of the International Bill of Rights as well in line with the Charter of the

United Nations find that the principles that established the Constitutions are basic to happiness, harmonious relations, and security for all people. However, special protection of formal care providers could not have been the best for security in the wards, which are very relevant in ensuring continuos care and provision of social support.

The findings on the culture and religion suggest that across the three facilities, cultural and religious beliefs lead to affect care and recovery processes. These cultural issues lead to relapse of cases in that some of the patients refuse medication as a direction from people of religious faith. Similarly, because of the belief in the evil spirit as the causes of the sickness, some patients refuse to come for review on time and rather spend all the time at prayer camps and spiritual homes consulting deities. Although, the religious believes promote a considerable amount of social support (Pargament, 2007; Smith, 2003), the medical aspect could correspondingly complement the social support for speedy recovery. Omalayo et al., (2013) said that mental illness could be diagnose effectively through medication and psychotherapy, which involves various levels of social support. Some patients for example, who have been told by their pastors that the cause of their condition is from "spiritual worms" or "someone who does not wish them well". This affects adherence to medication and time for review with a doctor. There is also the situation where some patients who refuse opposite sex to see them sometimes lead to delay in treatment.

This finding of attribution of causes to mental illness and its effects on health delivery relates to what WHO (2005), found in Haiti where for example, a range of factors were used for explaining illnesses based on cultural and social beliefs. Mental health illness is as supernatural forces and it is as consequence of spell or curse transmitted by jealous persons (WHO, 2010).

Summary

The chapter looked at the main constraints that caregivers face in providing social support and care for the mentally challenged in the three facilities. For the informal caregivers these were financial constraints, poor health of caregivers, social and cultural constraints and constraints of time. For the formal caregivers: funds and drugs, family neglect and security challenges were the main constraints found.

CHAPTER NINE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter provides a summary of the key findings, conclusions that include reflections on methodology employed and conceptual framework. Again, policy implication and recommendations are proffered.

The natural human tendency to care for fellow humans in helping them with materials and care in a form of social support is potent in treatment of mental health problems. This is because being in a group of networks lead to beneficial relationship and communal love and caring for each other. Individuals are socialised to think about themselves in relation to their relatives. However, in supporting someone who had mental health problems, it needs a combination of both clinical and social support for the mentally challenged to be managed and coped. This will happen in a free society where there is no discrimination and in an atmosphere of love and peace. This study was undertaken to, (1) investigate the types of support and their sources for mentally challenged; (2) assess effects of social support on the mentally challenged, and (3) explore the constraints on caregivers in caring and providing social supports for the mentally challenged.

Positivist and interpretive approach to the study of the phenomenon inform this study. It is exploratory and employed both qualitative and quantitative approaches to the study of socially related issues that have effects on mental health. Data were collected from four sources; Interview questionnaire for 409 inpatients which included the use of four different instruments; Socio-demographic, Social Network Index, Multidimensional Scale of Perceived Social Support and Social Relationship Index. There were In-depth Interview Guides for 23 of the outpatients, 10 of the facility personnel and 10 of the caregivers on social support, and care for the patients. Both qualitative and quantitative analysis was employed to answer the questions. Frequencies and tables were generated to study the various patterns and measures of support. Statistical Package for Service Solution Version 20 allowed the use of both descriptive statics and binary logistic to answer the questions.

Summary of the Main Findings

Based on the study, the following are summarised as the main findings:

1. With the qualitative data, it revealed that with functional social support, patients received emotional support such as love and acceptance by the family. Others received instrumental support such as food, medicine and money. Others received informational support also, such as information about their illnesses and advice.
2. It was found that patients who were 40 years and above (OR-0.192, $p<0.000$) were less likely to have close friends of at least one, less likely to have group members (OR-0.421, $p<0.000$) as visitors and less likely to see and talk to relatives (OR-0.371, $p<0.017$) in a month while on admission.It was found that patients who were married (OR 2.447, $p<0.031$) were more likely about 41 percent time to have close friends, receive more group members as visitors (46 percent more OR 2.182,

p<0.025) as well as see and talk to relatives (OR 2.176, p<0.054) compared to those who were single.

3. Patients with higher socio-economic status (education, OR 2.389, p<0.008) were more likely to have access to social support from friends, significant others about 59 percent OR 1.700 and then from the family (OR 2.053, p<0.008) than patients with basic education. Patients with income levels above 500 Ghana cedis reported social support from the family (62.3 percent) compared to patients whose income were below 500 Ghana cedis. Again, proportion of patients who get support from significant others is 68.7 percent, whiles 32.3 percent reported having been supported by friends.
4. The results suggest that, patients who frequently attended Church or Mosque were 2 times more likely (49 percent OR 2.049, p<0.014) to have close friends. Again, have group members and receive neighbors (58 percent more, OR 1.737, p<0.042) as visitors and receive relatives as well as talk to them (60 percent more 0R 1.662, p<0.065) than patients who do not attend church. Patients from nuclear family background could have access to social support compared to those from the extended family. Patients from extended family setting were dissatisfied (64 percent), conflicted (63 percent) and could not predict (68 percent) social support from the family.
5. On sources of social support, patients with less than 6 months' stay were more likely to receive support from the three sources than those with 4 years stay at the hospital. For example, patients with more than four years stay were less likely to receive support from the parents and

significant others (-234 percent less OR = – 0.427, p<0.003) and the family (OR= -0.548, p<0.039). For the patients with 6 months stay, it could be that the family members are still in touch, people might not have known about the condition, and so they get their regular support. Those who stay at the hospitals 4 years and above, the cost for staying long is a factor, family members were tired, and some of them have forgotten about them.

6. Gender and sources of social support show that males were more likely to receive support (93 percent, times OR= 1.926, p<0.006) from the family than females. However, females were more likely to receive social support from significant others than males.
7. On assessment of social support, both logistics and bivariate report show that female patients were more likely to receive positive than negative social support whiles 68 percent of male patients were more likely to receive negative social support from parents and significant others. For instance, male patients (OR= 2.359, p<0.003) were likely to have mixed feelings about social support from the family and (46 percent more, OR=2.151, p<0.016) were likely to have mixed feelings with support from significant others. In addition, 64 percent of the males reported negative support as against 51 percent of the females.
8. Patients who were employed before their condition were more likely (41 percent) to receive and interpret social support as negative from parents and significant others than the unemployed. For instance, they were more likely to be dissatisfied (OR= 2,434 p<0.005) be in conflicts (OR= 2.151,

$p<0.015$) with parents and significant others in provision of social support.

9. Caregiving has financial and employment constraints on informal caregivers. The demands of providing care has created financial difficulties and time spent on caring has prevented caregivers in engaging in full time jobs. This has worsened the financial situation of many of them. Inadequate and in some wards, absence of security is creating problems for caregivers and preventing care as well as posing danger to caregivers and patients themselves.
10. The findings suggest that one major constraints facing the formal caregivers is that of funds which has transferable effect on many other operational areas like drugs and basic logistics to run the facilities as well as contributing to major constraints of informal caregivers.

Conclusions

Some of the patients receive functional, instrumental and informational support, which helps them to cope.

There is low support for those who are above 40 years and beyond because at age 40 and beyond, friendship and social relationships begin to shrink and aging tends to relate to lower social support.

Church attendance could draw more support for the patients because of group membership and making of many friends, which one could depend on for support. Again, as they sing and engage in many activities in the church they tend to forget about their problems.

Patients with basic education and income less than 500 Ghana cedis could have low level of resources because of low income including social capital, which could affect immensely the social support, especially at the community level. Education has a linkage with income in that it could lead to unemployment thereby having difficulty with income for resources.

There is a low support for patients with longer stay, thus, 4 years and above at the hospital. Some family members do not want to associate themselves with their relatives in the hospital because, they are perceive to be mad.

Employed patients before the admission were more likely to interpret their support more inappropriate than the unemployed were. Work enables people to earn a livelihood and be economically secure. The employed patients have work before the condition. Now the sickness took them away from their work. What they use to do, is lost because of the condition, which could be irritating. The support received therefore will mean nothing to them but rather, think about their work.

Absence of securities at the wards affects care and recovery. It affects formal caregivers and poses danger to patients those who are calm and aggressive patients. Patients do escape, harm other patients and cause danger to other staff. Aggressive patients cause fear and panic in the facilities, which could prevent care and recovery.

Inadequate funding of the psychiatric hospital in the country has affected getting drugs and basic equipment for care. One could draw a lesson that inadequate supply of some essential medicine could lead to relapse of mental illness and worsen the long efforts of caregivers.

Refletion on the Methodology and Conceptual framework

Mixed method approach that triangulate quantitative and qualitative approaches were use. The strength of the mixed method research was that it drew on the intersecting strengths of each approach while reducing their weaknesses. This was important for rigorous analysis as in the logistics regression model, as well as drawing on thematic theme analysis, which improved reliability and validity of the results.

From the conceptual framework, it could confirm that the elements applied to the study. For example, social environment in which the socio-demographic variables serve as independent variable, then resources within the environment determined whether patients get social support or not. Again, social support could be as inappropriate because the situation, in which mentally challenge were, required different support at different time. In addition, caring for the patients required love and patience and at certain times can be very demanding as reflected in the finding.

It can be inferred that the density of network could be explaining the reason why some mentally challenged were left to roam on the streets whiles others are cared for by their spouses, family or significant others no matter the level of the condition. That, before one gets a support of whatever kind one must belong to a group or have an interpersonal relationship. It is in this regard that group membership such as church groups, clubs and other social organisations are very important. However, the same support that could make one cope could as well make one feel isolated if not appraised well.

Recommendations

Based on the findings and conclusions drawn, the following submissions are for consideration by various stakeholders:

The finding that some of the mentally challenged receive social support should continue. Ghana Health Service/Ministry of Health should work on educating the public on the important role of social support to sustain and enhance it. Fostering a strong bond between family and the various mental health facilities and strategies that will lead to embarking on the integrative approach in providing a continuing support for the mentally challenged in our communities' whiles they receive care in the hospitals. In addition, by encouraging group, network support, church groups in our communities' civil organizations to continue to provide social support.

The study found that those who were above 40 years do not get social support from friends, and even receive visitors. Government of Ghana could target these groups through Livelihood Empowerment against Poverty (LEAP) and other social intervention in reaching out to them. Besides, the District Assembly Common Fund's 2 percent to people with disabilities should also target mentally challenged in Ghana especially those aged 40 and above.

Various religious groups should support mentally challenge patients by providing love and care. They should also support those who could not attend Church and Mosque. They could take advantage of the psychiatric hospital free open door policy to pay visits, supply food and interact with them.

Government of Ghana through its Social Protection Strategy could support the vulnerable people especially mentally challenged who are in these difficulties with low level of education and those whose income are less than 500 Ghana cedis.

Patients with less than 6 months' stay were more likely to receive support from the three sources than patients who stay 4 years at the hospital. Occupational Therapist at the various hospital could support those on admission for 4 years and above in a model of social skill training where patients could be taught to engage in backyard gardening, bead making, basketry. They could earn income from the produce for personal upkeep as well as acquiring a skill while they are recovering. When hospitalisation is necessary, both clients and network members should remain in contact throughout. The Psychiatric role should include an assessment of a patient's social network and social support on regular basis.

Absence of securities at the wards affects care and recovery. Ghana Health Service as a matter of urgency should request for security from Ghana Police Service at the wards and at the main gates of the psychiatric hospitals. This could calm down fear; prevent some of the mental challenged patients from running away and causing fear to caregivers. A private security could be employed for all the three facilities. Government as a matter of urgency through Ministry of Finance should release funding for the hospitals in order to pay debtors as well as get medications and necessary logistics for care.

Contribution to Knowledge

The work has contributed significantly to mental health literature in the field of social support. One significant contribution of the thesis is that, the social environment in which exists the socio-economic environment, socio-demographic characteristics and political environment shaped and influence social resources and social capital that include network structures and their characteristics. These provided for psychosocial mechanism, which included social support in which functional, structural support influences mental health positively or negatively.

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APPENDICES

Appendix 1: Selected Authors and Themes

Authors	Theme	Method
1. Atefoe, et al. 2014	1. The Moderating Role of Stress on the Relationship between Religiosity and Mental Health among Women in Ghana.	Cross-sectional survey design
2. Barker, C. B. & Pistrang,N. 2002	2. Psychotherapy and social support: Integrating Research on psychological helping	Qualitative
3. Fournier, O.A. 2011	3. The states of Mental Health Care in Ghana	Mixed Method approach
4. Cohen, S. 2004	4. Social Relationships and Health	Literature Review
5. Lourel et al., 2013	5. social support and health	Cross-sectional
6. Uchino et al., 2004	6. Heterogeneity in social networks: a comparison of different models design linking relationships to psychological outcomes	Cross-sectional
7. WHO, 2014	7. Social determinants of mental health	Collaborated and thematic review
8. WHR, 2013	8.	
9. Thoits P.A 2011	9. Mechanisms Linking Social Ties and Support to Physical and Mental Health	Literature review
10. Feeney and Collins 2014	10. A New Look at Social Support: A Theorctical	Literature review

	Perspective on Thriving Through Relationships	
11. Mc Dowell, T.L., & Serovich, J.M. 2007	11. The effect of perceived and actual support on mental health of HIV-Positive persons	Theoretical review
12. Uchino, 2009	12. Understanding the Links between Social Support and Physical Health	Theoretical review
13. Cruwys et al., 2014	13. Depression and Social Identity: An Integrative Review	Literature review
14. Siedlecki et al 2013	14. The Relationship between Social Support and Subjective Well-Being across Age	Structural equation modelling
15. Golden et al., 2009	15. Loneliness, social support networks, mood and wellbeing in community-dwelling elderly	Mixed Methods
16. Aminu Sanda & Sackey, 2011	16. Social support as Mental Health Improver for Managerial Women in the Organizational Work Environment 17.	Quantitative method
17. Chen, Snyder and Krichbaum, 2001	18. Clinical use of tai chi in elderly populations.	Cross-sectional comparative
18. Simon, Chen & Dong 2014	19. Prevalence and correlates of elder mistreatment in a community-dwelling population of U.S. Chinese older adults.	Quantitative secondary data

19. Sharir, Tanasescu, Turbow and Maman, 2007	20. Social Support And Quality of Life Among Psychiatric Patients In Residential Homes	Mixed Method
20. Sexton, Olstad &Sogaard, 2001	21. A prospective population study of the social support buffer hypothesis specific stressors and mental distress	Quantitative Secondary Data
21. De Menil et al., 2012	Symptoms of Common Mental Disorders and their Correlates among Women in Accra, Ghana: A Population based Survey	Quantitative Cross-sectional
22. Campion, Bhugra, Bailey & Marmot, 2013	22. Inequality and mental disorders: opportunities for action	Quantitative
23. World Bank and WHO (2016)	23. Out of the Shadows: Making Mental health a Global Development Priority	Quantitative review
24. Araya, Rojas, Fritsch, Acuna, Lewis 2001	24. Common mental disorders in Santiago, Chile: prevalence and socio-demographic correlates	Cross-section HHS
25. The Human Development Report 2015	25. Work for Human Development	Thematic review
26. Barr and Simons, 2014	26. A Dyadic Analysis of Relationships and Health: Does Couple-Level Context Condition Partner Effects?	Quantitative

27. Whisman, Uebelacker, & Settles, 2010	28. Marital distress and the metabolic syndrome: linking social functioning with physical health	Quantitative
29. Gyekye 1996	29. African Cultural Values: An Introduction	Qualitative
30. Underwood and Teresi, 2002	30. Daily spiritual experience scale	Quantitative
31. Cummins, Ellaway & Macintyre, 2002	31. Place effects on health: how can we conceptualise, Operationalize and measure them?	Quantitative
32. Bell and Rubin, 2007	Why Place Matters: Building a Movement for Healthy Communities	Quantitative
33. Don, Mickelson & Barbee 2013	Indirect support seeking and perceptions of spousal support: An examination of a reciprocal relationship	Quantitative Secondary Data
34. Armstrong & Kammrath, 2015	Depth and Breadth Tactics in Support Seeking	Diary study
35. Tawiah, Adongo & Aikings, 2015	Mental Health-related Stigma and Discrimination in Ghana: Experience of Patients and their Caregivers	Mixed Method approach
36. Umberson and Montez, 2010	Social Relationships and Health: A Flashpoint for Health Policy	Quantitative
37. Cain, 2012	Voices of the Marginalized: Persons with Disabilities, Older People, People	

	with Mental Health Issues	

Appendix 2 Informed Consent

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD

INFORMED CONSENT FORM

QUESTIONNAIRE INTERVIEW GUIDE FOR PATIENTS AT THE MENTAL HEALTH HOSPITALS

Title: Social Support for the Mentally Challenged Patients in Psychiatric Hospitals of Ghana

Principal Investigator: Frank Mawutor Borbor

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General Information about Research

World Health Organisation states that there cannot be health without mental health because it has affected other diseases which cause death among people in the world. The importance of this disease has led to its inclusion by United Nations in the Sustainable Development Goals. Mental health illness is an area that has not been given attention for a long time and has been noticed to be very important in the world in alleviating poverty and human rights abuses. Unfortunately, mental well-being of people in Ghana has not been given much needed attention. This has led to neglect of people who suffer mental health conditions. The love and care for fellow humans in supporting them in social networks in a form of social support has been great in treatment of mental health problems. Studies and practices in Ghana on mental health however have been in most cases medical ones and few studies on social support for the mentally challenged have not discovered the several aspects of social support for the mentally ill. This study which is PhD, therefore will explore available social support and its effect on the mentally challenged.

Procedures: In order to understand the treatment and various social supports and care for the mentally ill, at the various facilities, you have been selected to be interviewed on various support and treatment at the facility. Your experiences in living with this condition will be helpful to the research team in getting information on mental health delivery as well as issues bordering social support among patients at this facility. There will be specific information on care and treatments, psychosocial rehabilitation, rights of persons who are mentally ill, challenges in providing care for in-patients and out-patients as well as supports from care-givers and family members. This interview will be moderated by myself or a research assistant.

If you do not wish to answer any of the questions posed during the interview, you may say so and the interviewer will move on to the next question. The interview will take place at the hospital premises or any location within the hospital premises convenient to you and no one else but the interviewer and your care giver will be present. At any instance you would wish your care giver to be excused it will be granted.

Duration of discussion

This will last between 45 minutes and 1 Hour depending on the questioning format and your approach in answering the questions.

Possible Risks and Discomforts

There is no anticipated risk however there may be discomfort giving the nature of questions that involve issues on mental health however appropriate arrangement such as recruiting a senior nurse counsellor who will be available for counselling for you to be okay.

Possible Benefits

The finding from the research could influence policy viewpoints on mental health delivery especially integrated approach of social support for the mentally challenge which could reduce human right abuse of persons with mental health problem. This could also give a sense of agency to governments to quicken recommendations and approaches to treatment of mental health which will have the overall effect of making safe the community of people with these conditions. The work as well is purely academic work and so there is no financial incentives attached to it.

Confidentiality

You are assured that any information you provide will be kept strictly confidential and be used only for the purpose of this study. Anonymity will be assured by the use of pseudonyms or codes to identify participants. Whatever information you give will be used for the purpose of this study. Codes will be used to identify all participants in order to prevent any personal identity. All paper transcripts will be kept under locked and key and soft copy documents will also be saved electronically and destroyed after five years.

Voluntary Participation and Right to Leave the Research

The research is voluntary and participants can withdraw their participation at any time without any problem. However, your contribution is valuable to this work.

Contacts for Additional Information

If at this time or any point you wish to raise any questions or seek further clarification on this study, you may contact my Principal Supervisor, Prof. A. Kumi-kyereme on 0244255234, kumikyereme@yahoo.com and Prof. K. Barima-Antwi on 0246143986, kantwi@ucc.edu.gh at University of Cape Coast, Department of Population and Health and Geography and Regional Planning respectively.

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of University of Cape Coast (UCCIRB). If you have any questions about your rights as a research participant you can contact the Administrator at the IRB Office between the hours of 8:00 am and 4:30 p.m. through the phones lines 0332133172 and 0244207814 or email address: irb@ucc.edu.gh.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title (name of research) has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

____________________ ____________________

Name and signature or mark of volunteer

Date

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

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

Date

Name and signature of witness

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.

Date

Name Signature of Person Who Obtained Consent

Appendix 3 Structured Questionnaire

QUESTIONNAIRE INTERVIEW FOR IN-PATIENTS AT THE PSYCHIATRIC HOSPITALS

Introduction

Globally and Ghana in particular it has been recognised that there cannot be health without mental health as a result of its significant contribution to the burden of diseases and mortality. Studies have shown that an integration of social support with clinical is effective in treatment of mental illness. Therefore, the study seeks to explore available social support for the mentally ill in Ghana and to advocate for the right type of social support in our mental health hospitals and in communities to improve mental health delivery.

Instruction: This questionnaire is to be administered by the research officer or research assistants at the facilities

SECTION A: SOCIO-DEMOGRAPHIC QUESTIONNAIRE

1. What is your age?
   a. 20-29
   b. 30-39
   c. 40-49
   d. 50-64
   e. 65 and above
2. What is your Gender?
   a. Male
   b. Female
3. Which type of family do you come from?
   a. Nuclear

   b. Extended family system

4. What is the number of family members you live with?
   a. 1-5
   b. 6-10
   c. 11-15
   d. 16-22
5. What is the highest level of education you have attained?
   a. Primary
   b. JHS
   c. Secondary/technical/vocational
   d. Tertiary
   e. Postgraduate
6. What is your religion?
   a. None
   b. Muslim
   c. Christian
   d. Traditional
   e. Other (please specify)
7. What is your ethnic background?
   a. Akan
   b. Ga/Dangme
   c. Ewe
   d. Guan
   e. Mole-Dagbani
   f. Grusi

g. Gruma

h. Other

8. What is your place of residence before this condition?

    a. Capital/Large city

    b. Small city

    c. Town

    d. Country side

9. How many times did you happen to attend church, synagogue, mosque, shrine or any other religious worship service in the last 30 days or less before your admission?

    a. Once

    b. 2 to 3 times

    c. 4 times

    d. 5 times or more

10. What is your estimated monthly income in Ghana when you were working before your admission in Cedis?

    a. Below 200

    b. 400-499

    c. 500 and above

11. What is your employment status?

    a. Formal employment

    b. Not employed

    c. Retired

    d. Informal employment

12. What is your marital status?

    a. Single/never been married
    b. Married
    c. Separated
    d. Divorced
    e. Widowed

13. How many children do you have?

    a. 0
    b. 1
    c. 2
    d. 3
    e. 4 or more

14. Do you have Siblings?

    a. Yes
    b. No

15. Are your parents alive?

    a. Yes
    b. No

16. What is the duration of your condition?

    a. A month to a year
    b. A year to three
    c. Three years to six years
    d. Six years to 9 years
    e. Above nine years

SECTION B: STRUCTURAL SUPPORT

Instructions: This questionnaire Interview is concerned with how many people patients see or talk to on a regular basis including family, friends, workmates, neighbours, etc. You will be asked the following questions by the Research Assistant for him/her to fill it out in the schedule and where necessary your care giver will assist in answering the questions

1. Which of the following best describes your marital status?

a) Currently married and living together, or living with someone in marital-like relationship

b) Never married and never lived with someone in a marital-like relationship

c) Separated

d) Divorced or formerly lived with someone in a marital-like relationship

e) Widowed

2. How many children do you have?

---0---1---2---3---4---5---6---7 or more ---0---1---2---3---4---5---6---7 or more

3. Is either of your parents living? (If neither is living, check 'O' and skip to question 4.) ---(0) neither---(1) mother only---(2) father only---(3) both

a. Do you see or talk on the phone to either of your parents at least once every 2 weeks? --- (0) neither--- (1) mother only--- (2) father only--- (3) both

4. Are either of your in-laws (or partner's parents) living? (If you have none, check the appropriate space and skip to question 5.)

---(0) neither---(1) mother only---(2) father only---(3) both--- (4) not applicable

a)Do you see or talk on the phone to either of your partner's parents at least once every 2 weeks?

---(0) neither---(1) mother only---(2) father only---(3) both

5. How many other relatives (other than your spouse, parents and children) do you feel close to? (If 'O', check that space and skip to question 6.)

---0---1---2---3---4---5---6---7 or more

a) How many of these relatives do you see or talk to on the phone at least once every month? Even as you are on admission ---0---1---2---3---4---5---6---7 or more

6. How many close friends do you have? (Meaning people that you feel at ease with, can talk to about private matters, and can call on for help) ---0---1---2---3---4---5---6---7 or more

a) How many of these friends do you see, visit you or talk to at least once every 2 weeks? ---0---1---2---3---4---5---6---7 or more

7. Do you belong to a church, temple, or other religious group? (If not, check 'no' and skip to question 8.) ---No---yes

a) How many member/rs of your church or religious group do you talk to at least once every 2 weeks? (This includes a group meetings and services.) ---0---1---2---3---4---5---6---7 or more

8. Have you been employed either full or part-time before your admission? (If not, check 'no' and skip to question 10.) --- (0) no--- (1) yes, self-employed--- (2) yes, employed by others

a) How many people do you supervise? ---0---1---2---3---4---5---6---7 or more

b) How many people at work (other than those you supervise) do you talk to at least once every 2 weeks? ---0---1---2---3---4---5---6---7 or more

10. How many of your neighbours do you visit or talk to at least once every 2 weeks?

---0---1---2---3---4---5---6---7 or more

11. Are you currently involved in regular volunteer work? (If not, check 'no' and skip to question 12.)

---no---yes

a) How many people involved in this volunteer work do you talk to about volunteering-related issues at least once every 2 weeks? ---0---1---2---3---4---5---6---7 or more

12. Do you belong to any group in which you talk to one or more members of the group about group-related issues at least once every 2 weeks? Examples include social clubs, recreational groups, trade unions, commercial groups, professional organizations, groups concerned with children like the PTA or Boy Scouts, groups concerned with community service, etc. (If you don't belong to any of such groups, check 'no' and skip the section below.)

---no---yes

Consider those groups in which you talk to a fellow group member at least once every month. Please provide the following information for each such group: the name or type of group and the total number of members in that group that you talk to at least once every month. Group that you talk to at least once every 2 weeks (Total number of group members)

SECTION C: QUESTIONNAIRE INTERVIEW ON PERCEIVED SOCIAL SUPPORT

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988) Instructions: We are interested in how you feel about the following statements. Research Assistants or officer will read each statement carefully.

Indicate how you feel about each statement. Research assistants are to circle various numbers indicating how patients feel about each statement.

Circle the "1" if patient **Very Strongly Disagree**

Circle the "2" if patient strongly disagree

Circle the "3" if patient Mildly Disagree

Circle the "4" if patient Mildly Agree

Circle the "5" if patient Strongly Agree

Circle the "6" if patient Very Strongly Agree

1. There is a special person who is around when I am in need.1 2 3 4 5 6 SO
2. There is a special person with whom I can share my joys and sorrows.1 2 3 4 5 6 SO
3. My family really tries to help me. 1 2 3 4 5 6 Fam
4. I get the emotional help and support I need from my family. 1 2 3 4 5 6 Fam
5. I have a special person who is a real source of comfort to me. 1 2 3 4 5 6 SO
6. My friends really try to help me. 1 2 3 4 5 6 Fri
7. I can count on my friends when things go wrong.1 2 3 4 5 6 Fri
8. I can talk about my problems with my family. 1 2 3 4 5 6 Fam
9. I have friends with whom I can share my joys and sorrows. 1 2 3 4 5 6 Fri
10. There is a special person in my life that cares about my feelings. 1 2 3 4 5 6 SO
11. My family is willing to help me make decisions. 1 2 3 4 5 6 Fam
12. I can talk about my problems with my friends. 1 2 3 4 5 6 Fri

The items tended to divide into factor groups relating to the source of the social support, namely family (Fam), friends (Fri) or significant other (SO).

Appendix 4 In-Depth Interview Guide

DEPARTMENT OF POPULATION AND HEALTH

IN-DEPTH INTERVIEW WITH OUT-PATIENTS AT THE MENTAL HEALTH FACILITIES

Title: Social Support for the Mentally Challenged Patients in Psychiatric Hospitals of Ghana.

Introduction

Globally and Ghana in particular it has been recognised that there cannot be health without mental health as a result of its significant contribution to the burden of diseases and mortality. Studies have shown that an integration of social support with clinical is effective in treatment of mental illness. Therefore, the study seeks to explore available social support for the mentally ill in Ghana and to advocate for the right type of social support in our mental health hospitals and communities to improve mental health delivery.

Section 1: Identification data

a. Date of the interview:
b. Place/District/Region:
c. Language use during the interview
d. Name of the interviewer
e. Time interview ended

Demographic data

a. Age in range
b. Gender
c. Ethnic background
d. Duration of condition or illness

e. Marital status

f. Educational background

g. Family system

SECTION 2: Perceived Emotional Support

1. How do you feel about your conditions as well as your relationship with friends, wife, and your family members since you have been affected with this condition?
   a. Probe on whether the patient feels people truly like her/him
   b. Probe on whether the patient feels other people show that they are fond of her/him when not feeling well?
   c. Probe on whether he/she feels there is someone who will cheer him up whenever he/she is sad with the condition
   d. Probe on whether patient is normally comforted or has someone who will comfort him/her

SECTION3: Perceived Instrumental Support

1. Do you feel that any time you need anything in your condition someone special is always there to provide those things for you?
   a. Probe on whether patient has some one he can always rely on
   b. Probe on who patient thinks comfort when worried. Probe on the care-giver
   c. Probe on people who offer help when patient need it

SECTION 4: Actual Received Support

1. Think about the person who is closest to you, such as your spouse, partner, child, friend, and so on. What kind of support did you received from them in the past weeks?

a. Probe on showing of love and acceptance (EMO)

b. Probe on physical presence of someone when need to talk to (INST)

c. Probe on comfort any time he/she feels bad

d. Probe on whether patient thinks he/she is left alone. If yes who left you alone? (-) (EMO

e. Probe on whether patient think someone did not show him/her much empathy for current situation. (-) (EMO)

f. Probe on whether patient has people who complain about him/her (-) (EMO)

g. Probe on people who complain about patient

h. Probe on patient's physical things such as food, clothed etc.(INST)

i. Probe on who valued and made patient feel important? (EMO)

j. Probe on who normally express concern about patient's condition(EMO)

k. Probe on whether the patient can rely on someone completely(EMO)

l. Probe on whether the patient find something positive of which someone assisted him/her(INF)

m. Probe on whether the patient was suggested with activities that are distractive(INF)

n. Probe on whether the patient is encouraged not to give up (EMO)

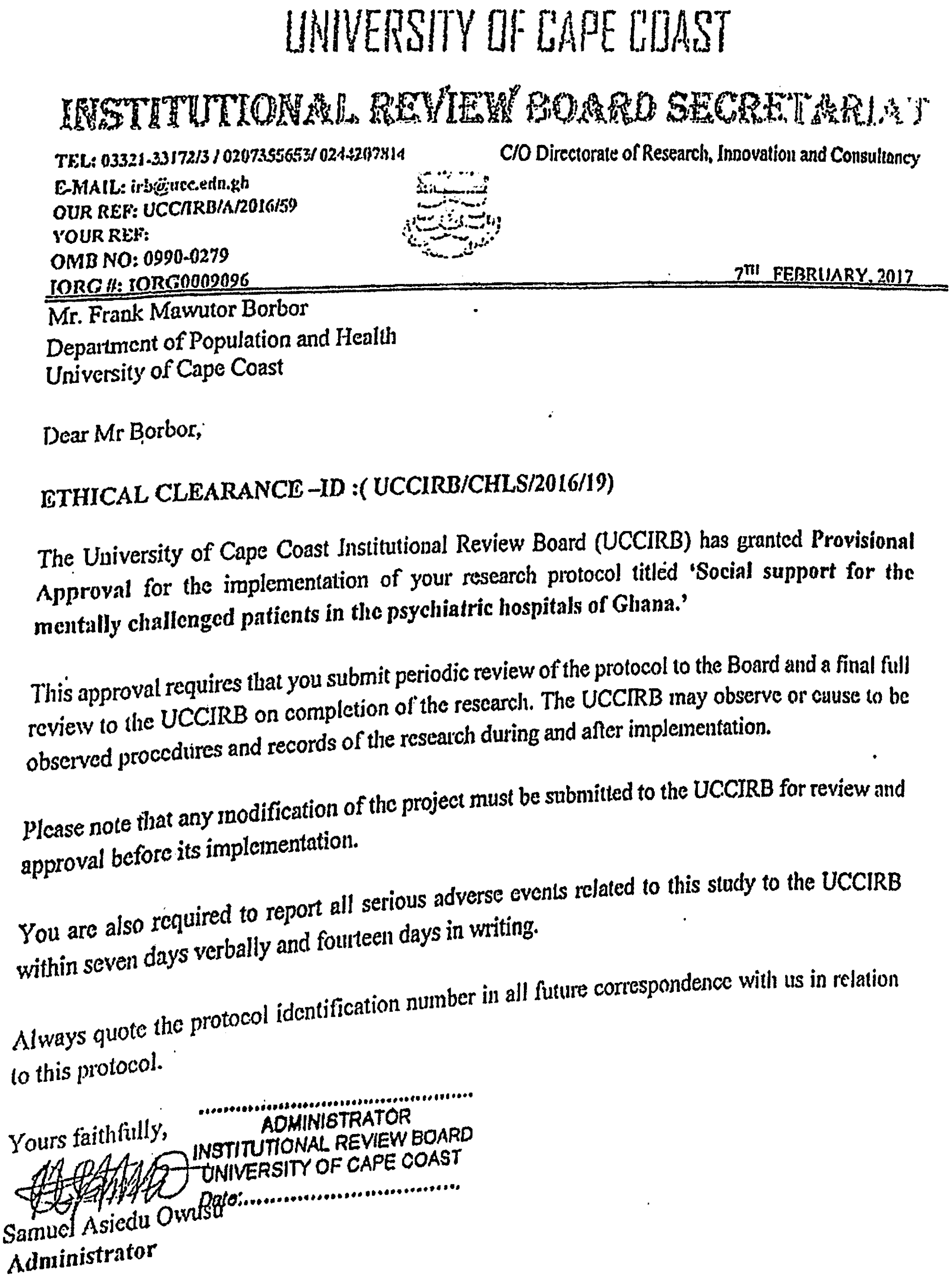
o. Probe on whether someone consistently takes care of things the patient cannot do? (INST) e.g. washing, taking drugs etc.

2. In general, are you satisfied with the way people including your care giver behave towards you (SAT)

3. Is there any other thing you would like to share with us?

Appendix 5 Ethical Clearance- Instititional Review Board Secretariat

University of Cape Coast



UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

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C/O Directorate of Research, Innovation and Consultancy
E-MAIL: irb@ucc.edu.gh
OUR REF: UCC/IRB/A/2016/59
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

7TH FEBRUARY, 2017

Mr. Frank Mawutor Borbor
Department of Population and Health
University of Cape Coast

Dear Mr Borbor,

ETHICAL CLEARANCE -ID :(UCCIRB/CHLS/2016/19)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol titled **'Social support for the mentally challenged patients in the psychiatric hospitals of Ghana.'**

This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

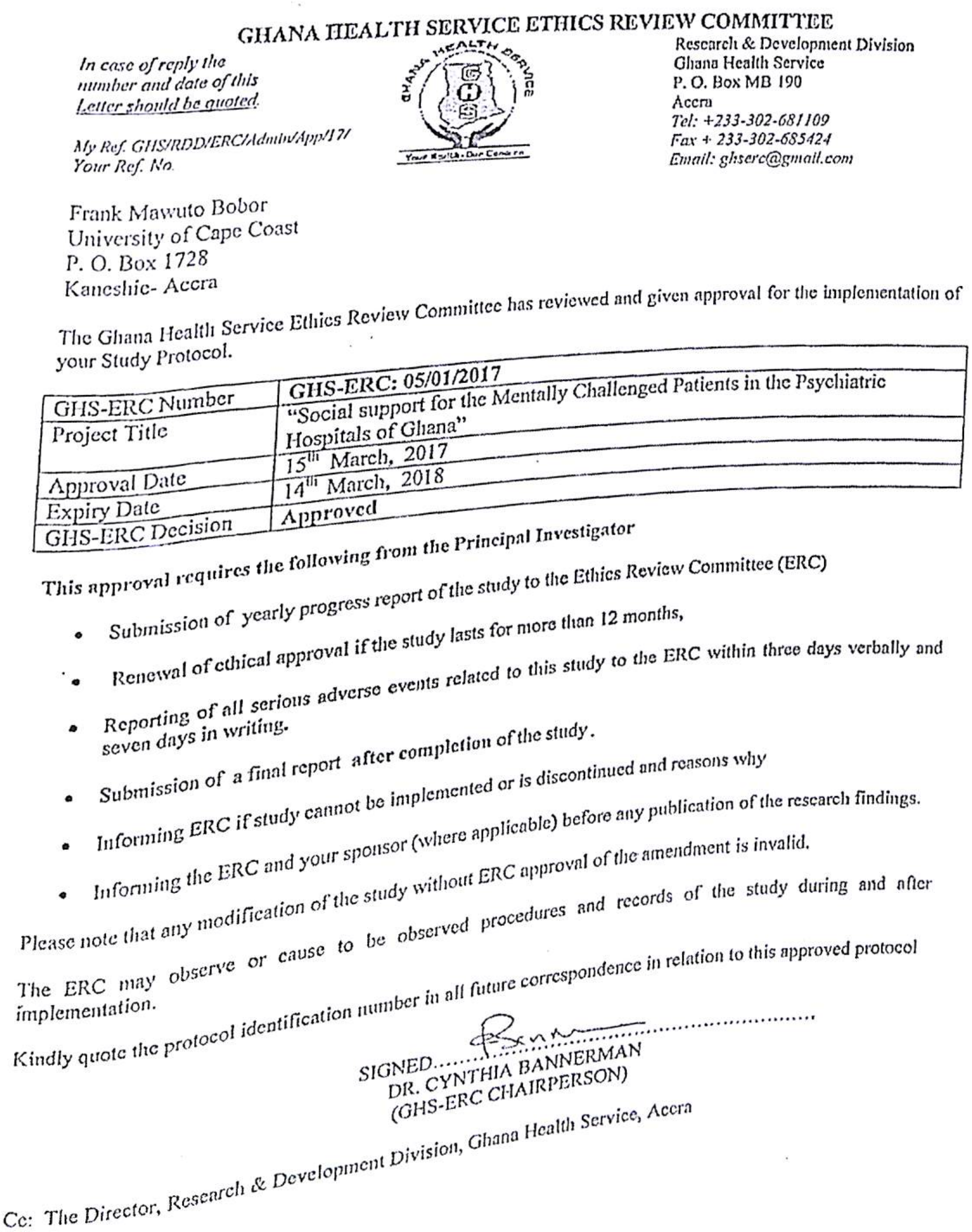
Yours faithfully,

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST
Date:................................

Samuel Asiedu Owusu
Administrator

Appendix 6 Ethical Clearance Ghana Health Service Ethics Review Committee

Ethical Clearance



GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

Research & Development Division
Ghana Health Service
P. O. Box MB 190
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In case of reply the number and date of this Letter should be quoted.

My Ref. GHS/RDD/ERC/Admin/App/17/
Your Ref. No.

Frank Mawuto Bobor
University of Cape Coast
P. O. Box 1728
Kaneshie- Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	GHS-ERC: 05/01/2017
Project Title	"Social support for the Mentally Challenged Patients in the Psychiatric Hospitals of Ghana"
Approval Date	15th March, 2017
Expiry Date	14th March, 2018
GHS-ERC Decision	Approved

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study.
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED...
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra