EXPERIENCES OF REINTEGRATION AND HOMELESSNESS AMONG MENTAL HEALTH CARE USERS WHO HAVE BEEN TREATED AND DISCHARGED FROM THE ACCRA PSYCHIATRIC HOSPITAL – A QUALITATIVE STUDY

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DECLARATION

By submitting this dissertation electronically, I Beatrice Dwumfour Williams, declare that apart from references cited which have been duly acknowledged, conducted this research under the concomitant supervision of Sarah Skeen during the 2016/2017 academic year. This work has never been submitted in whole or part for the award of any Degree in the Stellenbosch University or for any other qualification.

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DEDICATION

This dissertation is dedicated with phenomenal gratitude and affection to my husband (Dr. Charles Dwumfour Williams) and my adorable sons (Melchizedek K. A. Dwumfour Williams, Charles K. S. Dwumfour Williams Jr. and Zebediah-Zane K. O. Dwumfour Williams) and to my parents - Rev. Ramson and Mrs. Florence Asante Darteh and sisters – Rita, Blessing and Ivy for their motivation and support, and to all mental health professionals and service users in Ghana. God bless.

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ABSTRACT

Reducing homelessness and challenges associated with social reintegration among MHCUs is of core interest to health care providers. However, it appears attempts at reducing homelessness while socially integrating MHCUs have been fraught with more complications than anticipated. Aims and objectives therefore were to (1) explore perceptions and experiences of MHCUs' homelessness after they have been treated and discharged from the Accra Psychiatric Hospital in Ghana; (2) gain an understanding of the challenges of reintegration of MHCUs back into their families and societies after discharge from mental hospitals; and (3) explore issues, which may support or be a barrier to reintegration including family factors (support, resources), mental health history and beliefs around illness, and access to mental health services. Using a descriptive qualitative method, 15 MHCUs were purposively sampled and interviewed from the Accra Psychiatric hospital. This included 7 males and 8 females within the ages of 21 and 69 (mean age of 46.6 years). From framework analysis four (4) major themes and twelve (12) sub-themes were identified as the experiences of homelessness among MHCUs who have been treated and discharged from the Greater Accra Psychiatric hospital. With the first major theme – Individual factors – issues affecting homelessness and reintegration such as the issue sense of worth/belongingness, and concerns for health/wellbeing after discharge were found. The second major theme – family factors – also revealed factors such as the lack of will or readiness of family, marginalization from family, issue of stigma and financial constraints as affecting homelessness and reintegration. The third theme was community factors where subthemes - general misconceptions about mental illness and stigma with marginalization were found. Finally, the fourth major theme - institutional factors – with subthemes - poor admission and

discharge procedures, lack of proximal mental health facility/service and material benefits from the psychiatric hospital was found. These findings support most literature reviewed for the study and is well explained by the Afrocentric Worldview. Implications are thoroughly discussed.

Key words: homelessness, social reintegration, barriers and facilitators

OPSOMMING

Die vermindering van haweloosheid en die uitdagings wat verband hou met sosiale herintegrasie onder geestesgesondheidsorggebruikers is van kardinale belang vir gesondheidsorgverskaffers. Dit blyk egter asof pogings om haweloosheid te verminder, gepaard met die sosiale integrasie van geestesgesondheidsorggebruikers, belemmer word deur verskeie komplikasies. Doelwitte en doelstellings was dus om (1) die persepsies en ervarings van geestesgesondheidsorggebruikers se haweloosheid te verken nadat hulle behandel en ontslaan is van die Akkra-psigiatriese hospitaal in Ghana; (2) die uitdagings van die herintegrasie van GGSGs in hul gesinne en samelewing te verstaan na ontslaning van geesteshospitale; en (3) kwessies te ondersoek wat herintegrasie ondersteun of versper, insluitende gesinsfaktore (ondersteuning, hulpbronne), geestesgesondheidsgeskiedenis en oortuigings rondom siekte en toegang tot geestesgesondheidsdienste. Deur gebruik te maak van 'n beskrywende kwalitatiewe metode, is 15 GGSGs van die Akkra-psigiatriese hospitaal doelbewus gesteekproef en onderhoude mee gevoer. Dit sluit in 'n algehele gebruik van 7 mans en 8 vroue tussen die ouderdom van 21 en 69 (gemiddelde ouderdom van 46,6 jaar). Vanuit raamwerkanalise is vier/ (4) hoof temas en twaalf (12) subtemas geïdentifiseer as die ervarings van haweloosheid onder GGSGs wat behandel en ontslaan is van die Akkra-psigiatriese hospitaal. Met die eerste hoof tema – individuele faktore – is kwessies wat haweloosheid en herintegrasie beïnvloed gevoel van waardigheid/behorenheid, en bekommernisse vir gesondheid/welsyn na ontslaning, gevind. Die tweede hoof tema - familiefaktore - het ook faktore soos die gebrek aan wil of bereidwilligheid van die gesin, marginalisering van die gesin, kwessie van stigma en finansiële beperkinge wat dakloosheid en herintegrasie beïnvloed, onthul. Die derde tema was gemeenskapsfaktore met subtemas –

algemene wanoortuigings oor geestesongesteldheid en soos stigma met marginalisering. Ten slotte is die vierde hoof tema – institusionele faktore – met subtemas – swak toelatings- en ontslaningsprosedures, 'n gebrek aan proksimale geestelike gesondheidsfasiliteit/diens en wesenlike voordele van die psigiatriese hospitaal, bevind. Hierdie bevindinge ondersteun die meerderheid van die literatuur wat vir hierdie studie hersien was en word goed verklaar deur die Afrosentriese Wêreldsiening en Gesondheidsoortuigingsmodel. Implikasies word deeglik bespreek.

Sleutelwoorde: haweloosheid, sosiale herintegraie, verperrings and fasiliteerders

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LIST OF ABBREVIATIONS

AFFIRM	*AFrica Focus on Intervention Research for Mental Health*
GHS	*Ghana Health Service*
HREC	*Human Research Ethics Committee*
HIC	*High Income Country*
LMICs	*Low and Middle Income Countries*
MHCUs	*MHCUs*
MoH	*Ministry of Health*
NSHAPC	*National Survey of Homeless Assistance Providers and Clients*
OPD	*Outpatient Department*
QDA	*Qualitative Data Analysis*
WHO	*World Health Organisation*
WFRP	*Worcester Family Research Project*

CHAPTER ONE

INTRODUCTION

1.1 Background

Mental health and mental illness

The World Health Organization (WHO) conceptualizes mental health as a state of well-being in which one is capable of realizing his or her potential, deal with everyday challenges of life, engage in productive work and make meaningful contribution to society. In contrast to this concept, mental ill-health is impairment in functioning which interferes with the aforementioned description. Mental ill-health is the experience of symptoms of mental disorders, of which schizophrenia and depression are examples (WHO, 2001b).

Mental disorders can affect how people think, feel and behave which in turn may influence how they relate to others and themselves (Kim, Swanson, Swartz, Bradford, Mustillo & Elbogen, 2007; Stein, 2013). In essence, a mental illness may disrupt one's lifestyle by compromising one's ability to effectively perform basic tasks and keep routines, such as observing hygiene, feeding, running a home and caring for others. Symptoms of a mental illness may be experienced as: "a single episode, persistent, relapsing and or remitting, such that one may have to deal with it through a lifetime" (Mental disorders Fact sheet, WHO, 2014).

Mental health disorders are estimated to cause roughly one-third of "years lost due to disability" (YLD) among persons 14 years and older. Currently, mental and substance use disorders have been found to be the one of the major causes of disability worldwide. Predictably, it has been estimated that it may be the major singular cause of disease burden globally by 2030, specially, among women (Vigo, Thornicroft & Atun, 2016).

Mental disorders also significantly compound physical illness. MHCUs (MHCUs) are people who receive mental health care. Stigma related to mental disorders prevents MHCUs from seeking out or accessing mental health care, and this, eventually compromises their human rights (Kawachi & Bekman, 2010). Owing to the very complex nature of the disorder, MHCUs tend to grapple with the illness and other opportunistic general health and social challenges (Lefley, 2001). Notwithstanding these complications, most MHCUs often expect an improved or better life after receiving treatment (in hospitalization). Unfortunately, the reality is often less benign, with many having to live with stigmatization, social isolation (disintegration), broken relationships and homelessness (Drake, Essock, Shaner, Carey, Minkoff & Kola, 2001a).

Basic survival needs such as employment, access to decent accommodation and availability of health and social care services are either inadequately met or completely neglected. These issues, compounded by forced transition upon discharge from psychiatric care may place MHCUs at a higher propensity to not being able to successfully socially reintegrate (Morris, Popper, Rodwell, Brodine & Brouwer, 2009).

Apart from the individual directly affected by a mental illness, others such as family, friends and communities can be negatively affected (Wright, Callaghan & Bartlett, 2011). Regrettably, although mental health challenges place a huge burden on families and society at large, it remains one of the most under-resourced fields in global health. In Ghana for instance, statistics from Ministry of Health indicated that the Government spent a total amount of GhC 398,857,000 on health in 2011. Yet, in that same year, the actual expenditure on mental health was GhC 5,656,974 (1.4% of the total health spending). According to the report, the amount was significantly less that what was essentially needed to run the three main psychiatric hospitals (thekintampoproject, 2012; The mental health systems in Ghana, 2011/2012; Yankyera, (2016).)

The limited attention paid to mental health by policy makers has often impeded efforts at providing timely and effective services. The lack or insufficiency of accessibility to safe and reliable services has been continuously identified as a crucial hindrance to mental health care globally (Vigo et al., 2016).

Social reintegration

A lack of support for social integration, and resultant homelessness of MHCU in Ghana is increasingly becoming a major social and public health concern. In Ghana, many MHCUs discharged from mental hospitals end up living on the streets (de-Graft Aikins & Ofori-Atta, 2007) or returning to the hospital and living informally within the grounds.

In Ghana, it has been approximated that over 100,000 persons are homeless on any given night (National Population and Housing Census, 2010). Some people sleep in makeshift shelters while others sleep on floors in shops (Thesen, 2001). All individuals across these ranges of habitation are referred to as being homeless (de-Graft Aikins et al., 2007). While not all people who are homeless have mental disorders, mental disorders appear to occur more frequently among the homeless than the general population (Morris et al., 2009). Mental illness is a chief risk factor to consider in tackling homelessness (Reardon, Burns, Preist, Sachs-Ericsson & Lang, 2003).

There is limited evidence about social reintegration and risk for homelessness in Africa and Ghana in particular, especially among MHCUs. There is the need to examine the perceptions and experiences of MHCU with the aim of developing evidence-based policies to ameliorate the conditions preventing social reintegration and promoting outcomes such as homelessness – an important public health problem. This thesis is a modest attempt at filling this gap in the literature on the experiences of homelessness among MHCUs in Ghana.

1.2 Statement of problem

Ghana's Ministry of Health (MoH) is directly responsible for formulating policies, monitoring and evaluating health services. The MoH funds public health facilities, teaching hospitals and the Ghana Health Service (GHS), and monitors but does not fund private health service providers. Other allied governmental institutions and statutory bodies also provide financial support to health service delivery using internally generated resources and donor funds (Antwi-Bekoe & Mensah, 2009).

In the 2007 World Health Organization report "The Country Summary Series" (WHO, 2007), Ghana was estimated to have a mental health treatment gap of well over 95%, with only a small portion of the more than 3 million people in Ghana with treatable mental health disorders receiving treatment at one of the nation's three public psychiatric hospitals. Community psychiatric nurses who conduct home visits are only located in half of the districts of the country.

More than 70% of Ghanaians who seek mental health care do so outside the conventional health system, primarily to prayer camps or traditional healers (Ae-Ngibise, Cooper, Adiibokah, Akpalu, Lund & Doku, 2010). These traditional healers may be herbalists, spiritualists and or clergy. This is due in part to popular belief that spirits and or forces beyond one's control cause mental illness (Fosu, 1995). Others consult them because they believe these healers are more affordable, more available and less highly stigmatized than the hospital-based treatment (Ae-Ngibise et al., 2010). In some cases, MHCUs use both the formal and traditional healers concurrently. The largest and most commonly used government service is the Accra Psychiatric Hospital (APH).

Accra Psychiatric Hospital (APH) Admission and Discharge procedures

Admission and discharge policies at the Accra Psychiatric Hospital are guided by the Mental Health Act of 2012 (Act 846 of the parliament of Ghana). Service users may be treated on an outpatient basis or be admitted for inpatient care. For admissions, referrals may be made from a general hospital or as walk-in admissions. This is supported by article 39 section 2 of the Mental Health Act, which states "a person in

need of treatment for mental disorder may go directly, with or without referral, to a mental health facility for treatment" (The Parliament of Ghana, 2010 Act 846, p17). Discharge procedures of the psychiatric hospital are based on the Act 846 (Mental Health Act, 2012). MHCUs are discharged based on clinical judgment of the psychiatric team who determine whether or not the patient can continue treatment from home on outpatient basis, as well as cope with or performance of their domestic and work related activities without injury to self and others. However, when a MHCU requests discharge in writing against medical advice, the facility is required to grant the request within twenty-fours, "unless the patient meets the conditions for involuntary admission" (Mental Health Act 846, p18).

After a patient is judged to be suitable for discharge from the hospital, staff make contact with their family for possible pick up or in some cases arrange transportation (provision of cash or driver) for those not requiring someone to accompany them home.

Efforts by hospital staff to contact families are often met with hostility and antipathy (Outpatient Department Annual Report, 2016). Meanwhile, the continued stay of MHCUs in and around the hospital grounds beyond admission compounds the high costs of operating the facility and contributes to overcrowding. In 2010 about 1,200 MHCUs were being living in the facility even though it could only accommodate 600. The overcrowding necessitated a decongestion exercise in that year. This resulted in about 700 stable MHCUs being asked to leave the hospital following usual discharge procedures upon consultation with their families. In 2012, the decongestion exercise was repeated, which also resulted in about 600 MHCUs being asked to leave.

However, even though it was reported that the MHCUs left the hospital, the staff at the hospital noticed that most of MHCUs were living around and within the hospital precinct within two weeks. They concluded that a majority of them had not returned home but were living within the grounds or immediate area outside the hospital (Outpatient Department Annual Report, 2016).

At present the hospital operates at capacity with approximately 600 inpatients and 30 discharges per month (Outpatient Department Annual Report, 2016). Yet, many stay on in the hospital precinct after discharge.

Not much is yet known about the experiences of discharge and reintegration among those MHCUs discharged from the APH. It is most likely that such information on their experiences with its accompanying psychological and other social challenges will help inform efforts to improve the reintegration of people back into their homes and communities.

1.3 Research question

The main research question is:

What are the experiences of MHCUs who have been treated and discharged from the Accra Psychiatric Hospital but remain living in a state of homelessness in and around the hospital grounds?

1.4 Aims and objectives

The aims are to:

i. Explore MHCU's perceptions and experiences of homelessness after been treated and discharged from the Accra Psychiatric Hospital in Ghana.

ii. Gain an increased understanding of MHCU's perceptions of the challenges of reintegration back into their families and societies after discharge from mental hospitals.

iii. Explore issues, which may support or be a barrier to reintegration, including family factors (support, resources), mental health history and beliefs around illness and access to mental health services.

1.5 Significance of the Study

Knowledge from this study would aid in realizing some of the goals of the Mental Health Act in Ghana (2012). Article 54 sections 1 -3 of the Mental Health Act states 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"(Mental Act 846, p3).

Furthermore, knowledge on the experiences of homelessness among MHCUs who have been treated and discharged from the Accra Psychiatric Hospital will support efforts to provide the highest manageable standard of mental health care. Specifically, it would aid in effectively planning outpatient interventions and after discharge

services for MHCUs and their families, which could ultimately improve reintegration and prevent relapse.

CHAPTER TWO

LITERATURE REVIEW

By investigating the experiences of MHCUs that have been discharged from mental hospital services in Ghana, but who are living in a state of homelessness in and around the hospital grounds, the present study seeks to explore MHCU's experiences of homelessness in the context of their mental illness, and explore barriers and supporting factors relating to re-integration of MHCUs into their families and communities after discharge, with a focus on MHCUs discharged from the Accra Psychiatric hospital.

2.1 Key concepts

Homelessness

The United Nations Statistical Division (UNSD; 2008) defines two types of homelessness. "Primary homelessness" refers to people living in the streets without shelter, whereas **"**secondary homelessness" refers to persons with no place or fixed residence, including those who move between different types of accommodation. Homelessness is also referred to as a state of not having a home (place of residence) (HRSA/Bureau of Primary Health Care, Program Assistance Letter 99-12, Health Care for the Homeless Principles of Practice).

In Ghana, there is no official definition for homelessness (Tipple and Speak 2004). However, during the most recent nationwide population and housing census, the Ghana Statistical Service defined people not belonging to a household as homeless or non-housed (National Population and Housing Census, 2010). A household referred

to a group of people (related or non-related) who reside together in one house or compound and maintaining the same housekeeping arrangements. Other research in Ghana has described homelessness as when one does not have a home to belong to or family or friends to reside with in times of need, a definition which has likely been influenced by the local cultural belief that everybody belongs to a home (Owusu-Ansah, 2004, Owusu-Ansah & Atta-Boateng, 2016).

Drawing from these definitions, for the purpose of this study about MHCU discharged from a mental hospital in Ghana, homelessness is considered to be not only about the lack of a roof but also about the lack of accessibility and suitability of available accommodation. This is informed by the view of homelessness as lacking a 'home' not only a 'roof' by focusing on the core elements of 'home' which includes constructs such as: a sense of refuge, permanence, privacy, safety, dignity, security and the ability to control living space (Mallett, 2004).

Social integration

In the context of mental health, social integration refers to the inclusion and participation of people with poor mental health in their families and communities (Baumgartner & Susser, 2013). In the Cape Town Declaration of October 2011, the Pan African Network of People with Psychosocial Disabilities (PANUSP) describes social integration as the ability to vote, marry, form and sustain relationships, raise children, and be treated equally to others (PANUSP, 2011).

Social integration is increasingly considered a key outcome for psychiatric services. In most settings, deinstitutionalization is considered as critical for social reintegration

of MHCU, with the main point of care shifting from inpatient to outpatient care settings (Bauer, Kunze, Von Cranach, Fritze & Becker, 2001; McCulloch, Muijen & Harper, 2000; Pedersen & Kolstad, 2009). Though this may seem a recent innovation; deinstitutionalization goes as far back as the 1950s - when Goffman (1961) commenced extensive work on deinstitutionalization. The term then was used to describe shutting or scaling down large psychiatric hospitals and creating substitute services within the community. Svab (2012) reports that after the Second World War, focus started shifting from psychiatric hospitalizations to community-based services in England. From then till now increasing public awareness and drawing attention to abusive practices in the hospitals, changes in the attitudes of mental health staff and increasing research on the quality of life of MHCUs has reinforced the need for reintegration into society rather than distancing from society.

Chow and Priebe (2013) in a review of existing literature found that for most MHCUs, psychiatric institutions are closed systems. This closed system sets them apart from the rest of society, where their lives are determined by institutional routine and isolation from the broader society. Failure to reintegrate MHCUs leads to their social isolation. Social isolation is thus, seen as a torturous condition (Linz, 2013) since the capacity to relate with others has consistently been viewed as an important and naturally occurring aspect of human survival.

Poverty, homelessness and mental illness: social causation and social selection

In order to fully understand the experiences of MHCU in Ghana, and their risk of not having a home after discharge from inpatient mental health care, it is important to

consider the complex relationship between homelessness, poverty and mental ill-health.

People with mental illness are at particular risk of not having a place to live. Numerous studies have documented high rates of mental health problems in homeless people, with research suggesting a bi-directional relationship between mental illness and homelessness (Langle, Egerter, Albrecht, Petrasch & Buchkremer, 2005; Leff, 1993; Marpasat, 1999; Marshal & Jeered 1992; McGilloway & Donnelly, 2001; McHugo, Bebout, Harris, Cleghorn, Herring, Xie, Becker, & Drake, 2004; Middleton 2014; Motjabai, 2005; Murphy, Burley & Worthington, 2002; Nelson, Aubry & Lafrance, 2007; North, Smith & Spitznagel, 2004; Odell & Commander, 2000; O'Neill, Casey & Minton, 2007; Rogers & Pilgrim, 2014). This is also the case in Ghana and other low and middle income countries, where up to 90 percent of homeless persons are people with mental health disorders (BasicNeeds, 2010; Bird, Omar, Doku, Lund, Nsereko & Mwanza, 2010). This relationship is based on a vicious cycle of social selection and social causation factors. In other words, homelessness itself can result in a person suffering from a mental illness because of added stressors relating to life without family or shelter. On the other hand, mental illness can also lead to a person becoming homeless because of social drift, or lack of social and family support (Lund, De Silva, Plagerson, Cooper, Chisholm, Das, Knapp & Patel, 2011)

This relationship very much echoes that of the links between poverty and mental health. People living in poverty are at increased risk of being affected by mental illness, while mental illness itself places one at risk of sinking (further) into poverty

(Lund et al., 2011). In terms of social selection, it has been shown that individuals who live, or who have grown up in poverty are more likely to experience mental ill-health. Poverty is intrinsically alienating and distressing, posing effects on one's physical, emotional and behavioral development, and children in the most impoverished households are much more likely to have a mental illness relative to their counterparts in wealthier homes (Murali et al. (2004)). Culhane et al., (1994) also noted that homelessness is more likely to occur when MHCUs come from impoverished communities where are not sufficient resources to support them. Firdion and Marpsat (2007) suggest that growing up in poverty limits an individual's ability to access family resources, access work or acquire employable skills all of which have an impact on mental well-being. In addition, Funk, Drew and Knapp (2012) detail how poverty negatively influences successful integration of MHCUs into the community and reuniting with their families. On the other hand, in terms of social drift, people with mental illness are more likely to drift in poverty because of reduced capacity to work and increased health costs (Lund & Cois, 2018).

This is prevalent in all settings. In LMIC, Gureje & Bamidele (1999) study of homelessness in South-western Nigeria suggest that negative social outcomes often accompany mental illness. In their study among outpatients with schizophrenia, participants mentioned homelessness as one of the negative social outcomes of their mental illness, as well as problems with employment as well as social connections. In Uganda, Ssebunnya, Kigozi, Lund, Kizza and Okello (2009) found that MHCUs may not be able to work due to factors linked to illness. Even when they gain employment relapses requiring hospitalization or days off to attend clinics may affect the number of days they can be present at work, decreasing their productivity, income and

probability of promotion, pensions or health insurance coverage. As such, they found that MHCUs might not get the same opportunities at work to improve their skills and abilities and subsequently advance through the system.

Much of the research suggests however, that supportive community-based interventions could contribute to lessening the impact of poverty and mental ill-health on social outcomes. For example, Funk et al. (2008) suggest that mental health interventions that promote education and poverty alleviation can create a fair and conducive working environment for persons living with mental illness. Research from the United Kingdom has shown that MHCU are able to work productively when given equal and proper access to services and support, such as home visits, peer self-help, medication, counselling, vocational skills development and social support (Astbury, 2008). Wahlbeck, Cresswell-Smith, Haaramo and Parkkonen (2017) suggested that effective psychosocial interventions on individual and family level could mitigate poverty and inequality in mental health in LMICs. They mention that evidence suggested the lack of community outreach workers, or service-based interventions (social prescribing and debt advice) and restricted policy level interventions were related to how poverty influenced mental health outcome.

In the case of MHCU in Ghana, both social selection and social drift theories are likely to be important. In the case of the "secondary" type of homelessness experienced by the MHCU in this study, the experience of social drift factors which are preventing them from successfully reintegrating back into their families and communities, is likely to be exacerbated by existing social selection factors. In other words, the levels of poverty and social deprivation of the families and communities

from whence these individuals come is an important consideration in their reintegration.

2.2 Theoretical Framework

This study, which is aimed at exploring the experiences of homelessness as well as facilitators and barriers to reintegration among MHCUs at the Accra Psychiatric Hospital, adopted the Ecological model (Bronfenbrenner, 1979) and Afrocentric World View (Asante, 1980, 1991; Mazama, 2001) as the theoretical guides. These are described in more detail below.

The Ecological Theory (Bronfenbrenner, 1979)

The ecological theory was originally developed by Bronfenbrenner (1979) to describe the relationship between the individual and their environment how they interact and affect each other as a child develops. The system of relationships is referred to as the ecological system, which is categorized into microsystem, mesosystem, exosystem and macrosystem. An individual's development throughout the life course is strongly affected by influences at each layer and the variety of interactions that they encounter in their environment (Bronfenbrenner, 1989). Each system is dependent on the other, as changes in one system will have effect on other layers.

The ecological theory has subsequently been adapted and expanded to explain changes in other contexts beyond child development (McLaren and Hawe 2004). It is in this light that the theory is used in this study to examine the various mechanisms within the environment that influence MHCUs experiences of homelessness and reintegration. The theory is used in this study in order to deepen our understanding of

the levels and systems of relationships that influence MHCUs continued stay in the precinct of the Accra Psychiatric Hospital and what impacts reintegration back into their homes and society at large. Applying this theory to MHCUs' experience of homelessness and challenges with reintegration suggests that various interacting individual and environmental factors can be identified (Sturgeon, 2007; Kendler, 2008).

Microsystem

Bronfenbrenner (1989) describes the microsystem as the activities, rules, and interpersonal relations experienced by an individual in a face-to-face setting. This is the layer closest to the individual (MHCUs) level, through which the individual makes direct contact with their immediate surroundings. The microsystem thus describes the factors that most directly influence the MHCU. Important aspects include characteristics of temperament, personality, systems of beliefs, the family and immediate context.

The type and symptoms of mental illness that the MHCU is experiencing is an important microsystem factor with regards to reintegration. Psychiatric disorders as such schizophrenia, depression, anxiety and alcohol and substance use have been identified to be linked with risks of homelessness among MHCU (Phillips & Parsell, 2012). This has been shown in a number of high-income country (HIC) settings (Chamberlain, Johnson & Theobald 2007; Bassuk, Buckner, Weinreb, Browne, Bassuk, Dawson & Perloff, 1997). MHCU who are male or who use or abuse substances are also at increased risk of homelessness.

However, data from LMIC is limited. In South Africa, individual protective factors that promote successful reintegration include being female, having average to high level functioning, and minimal occurrence of behavioral problems and agitation or restlessness (Krüger and Lewis, 2011).

Svab (2012) describes reintegration from the mental health perspective as, all the things one has to do from the start of treatment until one's recovery goals are meet. Svab (2012) also confirms one of the major factors found to support reintegration is the opportunity to engage in work activities. Molodynki et al. (2010) also highlights the role of work role and socials skills in any reintegrating process. MHCUs have reported that work helps to reduce delusions and hallucinations as they get in touch with reality and exert purposeful energy with a sense of accomplishment. Further to that was the finding that MHCUs discharged from psychiatric hospitals that are reintegrated into communities and allowed to work are much less likely to be re-hospitalized than patients who are unemployed (Molodynki, 2010). Work is considered to be an essential factor since it increases social contact with other members of the community while also promoting a sense of worth for MHCU as they contribute to their communities (Wong et al., 2011).

Viron and Stern (2010)'s work from Boston, United States, supports the view that vocation or employment is a critical element in the social reintegration of MHCUs. They suggested a strengthening of the recent development of co-operatives and social firms, since they could be antidotes to mental illness related unemployment. They stress that functional links between mental health services and departments of

employment, welfare and housing could improve the quality of life of MHCUs living in communities.

Family and social relations are also important microsystem factors. At this level, the MHCU's relations influence them and they also influence their relations. For example, a MHCU's family's reaction to their illness may affect their beliefs and behaviour; at the same time, the MHCUs behaviour also affects the behavior and beliefs of their family. Some studies have found that MHCUs who experience homelessness after becoming ill, have lesser available and active emotional support, less regular contact with trusting network members, and more conflictual relationships than MHCUs who do not. (Bassuk & Rosenberg, 1988; Bassuk et al., 2006; Culhane, Metraux, & Hadley, 2001; Sturgeon, 2007). In Caton et al. (2000)'s study, quality family support in adulthood, especially financial support, appeared to be a crucial factor that kept MHCUs from experiencing homelessness. Findings from a qualitative study suggested that the absence or withdrawal of social support worsened the mental health condition of the individuals experiencing homelessness (McChesney, 1995). Even for homeless MHCU not living with their families, it is possible that residual bonds with family and friends can be helpful sources of material and emotional support (Bassuk et al. 1997). In this regard, Folsom et al. (2005) found that caregivers, friends and family are a great support to preventing homelessness among MHCUs. Pfeiffer et al. (2012) found peer-based interventions to help in successful mental healthcare.

Conversely, total loss of contact with family members provides a barrier to reintegration. Van Rensburg (2005) investigated community placement and

reintegration of MHCUs from long-term care facilities in South Africa. The investigation was on the basis of South Africa's Mental Health Act of 2002, which prescribed a shift to suitable community-based care, rehabilitation and reintegration of MHCUs into the community. Results of the study indicated that nearly half had not had contact with family since they were institutionalized. The loss of family contact appeared to prolong their retention in psychiatric institutions, even when they were ready for discharge.

In addition to providing social, financial, and emotional support, families often determine the type of care the MHCU receives. Their opinions and actions can either hinder or help MHCUs decision to seek mental health services and family relations can affect health and health care seeking and utilization behaviours. Family and marital support can predict better treatment outcomes for individuals (Sandberg, Miller, Harper, Robila and Davey, 2009; Trief, Sandberg, Greenberg & Graff, 2003). Families are also responsible for protecting the human rights of their family members. In some contexts in low resource settings (e.g. Sharma, 2016) MHCUs are sometimes locked up in confinement or chained by their families in order to control their behaviour and restrict their movement.

Noteworthy is the fact that, family members' influence on a MHCU is also in turn influenced by the larger systems (mesosystem, exosystem and macrosystem). Specifically, wider traditional beliefs and myths may hinder social reintegration. In Nigeria, for example, where mental disorders especially schizophrenia are often viewed as consequence of a curse from aggrieved or envious relatives or

acquaintances, it has been found that MHCUs are not treated with the same affection and empathy that other family members receive when ill (Ewhrudjakpor, 2010).

Mesosystem

The *mesosystem* refers to linkages and processes that take place between the individual and other members of the community beyond the immediate family (Bronfenbrenner, 1989). This includes aspects such as the health care system, as well as the attitudes, beliefs and resources of neighbourhoods and religious organisations who can both be protective and harmful to individual's mental health (Krüger, et al., 2011).

In terms of health care system factors at this level, the interaction that a MHCU has had with the health system is critical. Evidence from HIC shows that when discharge is planned for and appropriate community services are available to take over care, MHCU are more likely to experience more successful reintegration (Herman, Conover, Gorroochurn, Hinterland, Hoepner and Susser (2011).

On the other hand, the lack of an effectively structured discharge plan is also recognized as a key factor in predicting homelessness among MHCUs. The initial six weeks following discharge from inpatient psychiatric care is critical since it can be a very stressful time for MHCUs (Salize, 2007) and suicide risk is highest during this time (Qin & Nordentoft, 2005). In the United States and Canada, Folsom et al. (2005), Gaetz (2010) and Padgett (2007) suggested that most people exiting mental health facilities end up with inappropriate accommodation because of a lack of a structured discharge plan (Backer, Howard & Moran, 2007). Similarly, in a qualitative study by

Bonsack, Schaffter, Singy, Charbon, Eggimann and Guex (2007) with GPs, mental health and allied staff, law enforcement agencies engaged in the community network in Switzerland, poorly planned discharges was identified as one of the major challenges in the treatment and management of MHCUs. Other studies have shown that half of MHCUs who do not have a briefing or closure with an outpatient clinician subsequent to discharge from inpatient care do not present for their initial post discharge outpatient appointment (Olfson, Mechanic, Boyer, & Hansell, 1998 & Bonsack, Pfister & Conus, 2006). Moreover, MHCUs who are not provided with links to outpatient services present with twice the risk of re-hospitalization and deterioration in mental and physical health (Nelson, Maruish, & Axler, 2000). Although data is lacking, in Ghana, anecdotal evidence seems to suggest that unplanned discharge is one of the highest risk factors for lack of appropriate accommodation among MHCUs (Outpatient Department Annual Report, 2016).

Stigma is also a concern at meso level. Thornicroft et al., (2007) observed low rates of mental health literacy, negative attitudes towards MHCUs, and stigma among mental healthcare workers in the UK which influence how care was provided to MHCUs. Stigma can also affect help-seeking at the mesosystem level. Help-seeking (treatment for mental health problems) may be perceived as bringing shame to the family (Yeh, 2000) and to the larger community (Yang et al., 2008). At community level, a study in China found that stigmatising attitudes of the public was a major barrier to reintegration. Molodynki, Rugkasa and Burns (2010) argued that in China, discharging MHCUs to homes in the community does not necessarily guarantee reintegration into society. Ewhrudjakpor (2010) also found negative perceptions and discrimination as a barrier to successful reintegration of MHCUs into the community

in Nigeria. Ewhrudjakpor (2010) reports that mental illness is viewed as the outcome of a person leading what appeared to be an irresponsible life such as heavy use or smoking of marijuana. As such they should be left to suffer the consequence of their action.

Exosystem

The *exosystem* is composed of settings "that do not involve the developing person [MHCU] as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person" (Bronfenbrenner, 1979, p.25). In this layer, there is the larger social system in which the MHCU does not function directly. The structures at this level impact the MHCU's experiences by interacting with some structures in the micro and mesosystems (Berk, 2000).

Exosystem factors such as governmental funding, policy and legislation, the role of mental health professionals, and stigma and discrimination are all significant in enhancing or limiting social reintegration of MHCUs (George, Norman, Benjamin & Mukherjee, 2014; Sharaf, Ossman & Lachine, 2012; U.S. Department of Health and Human Services, 2001, WHO, 2001; Wolf, 2005).

Killaspy's (2006) research indicates that a lack of legislative, institutional or government backing can prevent the implementation of even the best laid out reintegration plan. Government commitment and support is essential for decentralization of services and development of community-based services to support reintegration. In countries where reintegration and decentralization has been

prioritized, the outcome is often below expectation due to other factors. These included lack of attention to structural, functional and financial issues (Killaspy, 2006). Government commitment must include allocation of resources for services to support successful discharge and reintegration (including appropriate accommodation). A study conducted in Slovenia by Svab (2012) found that governmental institutions had not apportioned the necessary resources (funding) needed to run community care centres. In practice, this meant that institutions were still overcrowded and under-staffed. Essentially, there is not much staff can offer to support MHCU pre and post discharge if financial assistance from mandated governmental bodies is delayed or withheld. This is relevant for Ghana, where dedicated government finances for mental health services are often not forthcoming (Abdul-Karim, 2016; Antwi-Bekoe et al., 2009; Omar, Green, Bird, Mirzoev, Flisher, Kigozi, Lund, Mwanza & Ofori-Atta, 2010).

In the Life Esidimeni tragedy that occurred in South Africa between 2016 and 2017, several hundred MHCUs were forcibly removed from private care and put into the care of community-based NGOs. The NGOs assigned to handle these patients had neither the experience, skills, licenses nor funds to provide adequate care for the patients (Bornman, 2017). Following the deaths of more than 140 people, the full extent of the poor treatment, abuse and human rights violations that were experienced was exposed (Makgoba, 2017). One of the many lessons that can be drawn from this tragedy is the need to extensive planning, appropriate resource allocation and capacity development required when developing community-based services.

WHO (2001) highlighted that the deinstitutionalization of MHCUs must to be connected to an improvement and up scaling of the health care system within the community into which they will be going. Tebeanu and Macarie (2013) investigated the role of education and knowledge in promoting mental health, looking at its implications in the process of community integration of former MHCUs in Romania. The study involved interviewing 12 mental health professionals from a psychiatric hospital in Romania. The views expressed suggested that differences in culture, subjective nature of assessments and competing theories of the mental health professions influenced how mental health was seen and promoted. This had an impact on how different professionals addressed aspects relating to recovery. In turn, these are implicated in addressing the recovery from mental disorders. Of interest though, was the finding that the professions demonstrated limited experience regarding social reintegration and transition processes. Thus, effective reintegration of MHCU post-discharge is likely to require ongoing capacity development of mental health professionals and the systems in which they work.

Macro system

Bronfenbrenner (1989) defines the *macrosystem* as "the overarching pattern of micro, meso-, and exosystems characteristics of a given culture, subculture, or other broader social context". This layer is comprised of cultural values, customs, and laws (Berk, 2000). The macrosystem has a cascading influence on all other layers.

Ewhrudjakpor (2010) mentions the role of media (social and traditional) in the general public's negative perception of mental ill-health. Their presentation of mental illness comprises predominantly negative depictions of MHCUs and mental health

institutions. The negative depictions reinforce stigma, which in turn impede the successful reintegration of MHCUs.

In Ghana, the broader society subscribe to a collectivist culture whereby individual agency is greatly ignored. Collectivist cultures place more importance on interpersonal success, social cohesion, and social support when compared to individualistic cultures, which emphasize individual achievement, independence, and autonomy (Kitayama & Markus, 1998). Individuals in the collectivistic societies have weak self/other boundaries and experience negative emotions that are as a result of the actions of another. However, although, the Ghanaian society is collectivistic, MHCUs do not benefit from the collectiveness but rather suffer marginalization, stimatization and shame which makes it difficult for reintegration to occur (Abe-Kim et al. 2007).

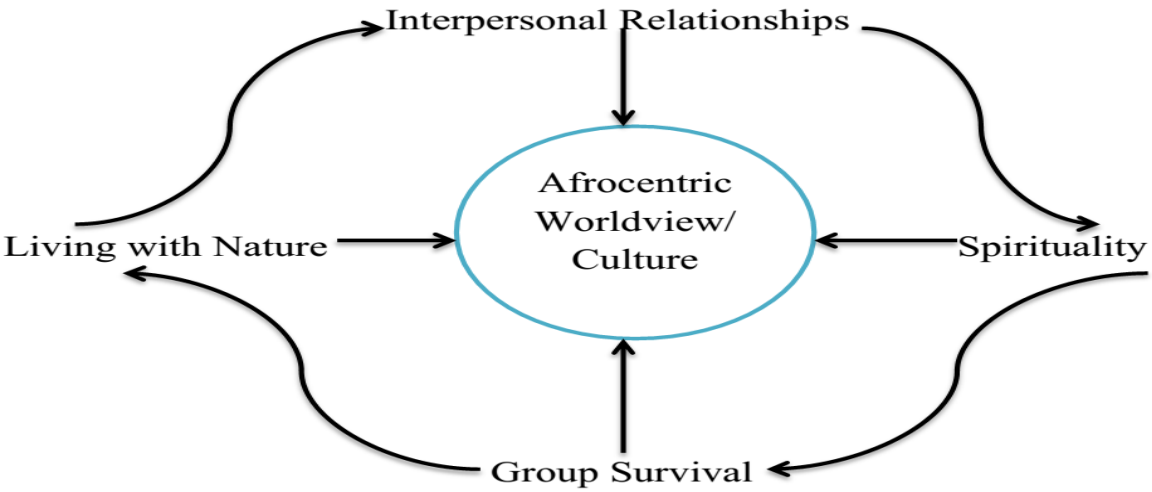
Afrocentric Worldview

The Afrocentric Worldview (Asante, 1991) is also of relevance for understanding the experiences of MHCU, at the macro level, but also in terms of its influence across each of the levels of the ecological model, in as much as there may be both positive and negative influences on many of the factors outlined above as a result of the influence of the value systems and culture within which the social reintegration of the MHCU is taking place.

Asante (1991) posits that Africans place value on aspects such as interpersonal relationships, spirituality, and living in accordance with nature. The main concept here is termed epistemological-centered Afrocentricity. African cultural values, as

described by Mazama (2001) emphasize that to Africans, the highest value of life rests in interpersonal relationships and interactions as humans. The survival of the group defines the utmost human relevance - the self is complementary of others. This theory extends to suggest that one should live in harmony with nature since it signifies oneness on the whole. Therefore cooperation, collective responsibility and interdependence are the significant values to which all should strive in order to meet the demands of the spirit. In that regard, all humans are considered alike, share a common bond and are part of the group.

Figure 1: Afrocentricity model (Asante, 1990)



The model (Figure 1) shows how interconnected factors shape one's worldview in African cultures, as described by Asante (1990). Interpersonal relationships, spirituality, group survival and living with nature are seen as the core, interrelated factors.

The Afrocentric worldview is relevant in this study of perceived homeless and its link to the barriers and facilitators of social reintegration of MHCUs. Asante (1990)

defined culture as the commonly held perceptions, attitudes, and predilections that permit people to order their experiences in unique ways. This fits into the idea of social reintegration where the Ghanaian who believes in the African values of group importance and harmony might have a positive view of social reintegration of MHCUs and accept any such relative into his or her family or community.

On the otherhand, a Ghanaian who believes in the African view of spirituality could view mental illness as something spiritual. Asante claimed that in the African context, things that are not directly discernible are safely left to the spirits. More practically, Ewhrudjakpor (2010) explained that in the African context, mental illness is not understood in physical terms; that is, most people are of the view that it is an affliction by the gods or ancestors or spirits for something bad done by the individual presently or in the past. In that case, it could serve as a barrier to successful reintegration. In addition, a spiritual view might make most people agree that such MHCUs should be confined to spiritual care in a secluded place until they are completely relieved. This could worsen the goal of successful reintegration.

Factors across multiple levels

It is important to note that there are factors that are present across multiple levels, such as stigma. Sartorius (2007) found stigma attached to mental illness to be a major hindrance to the provision of care. To the extent that the stigma is not restricted to the sufferer or illness: it tends to affect, their families across generations, institutions that provide care and treatment, the psychotropic drugs, and even mental health workers. Beyond the family and mental health services, stigma influences the low regard with which community and health decision-makers perceive MHCUs, resulting in

unwillingness to capitalize mental health care. Stigma, furthermore, leads to discrimination in the treatment MHCUs receive for physical illness.

2.3 Summary of Literature Review

This chapter presented an overview of the literature of homelessness and reintegration in Ghana and other parts of the world. It began with the definitions of homelessness and reintegration, outlining definitions that are applicable to this study's context. A background to the relationship between mental ill-health, homelessness, poverty and social integration followed this.

The ecological model was presented and a number of factors at micro, meso, exo, and macro system level that impact upon social reintegration of MHCU and their re-entry into appropriate accommodation post-discharge were described. Factors that influence reintegration across multiple levels, such as stigma, were also noted. Finally, the Afrocentric worldview model was also described, as an additional source of both positive and negative influence in social reintegration. Overall, there is little research, especially from LMIC, exploring the experiences of people who have been treated and formally discharged but remain in the psychiatric facilities. This thesis is therefore an attempt at addressing this gap in the literature.

CHAPTER THREE

METHODOLOGY

This chapter explains the methods used in this research. It begins with an outline of the study's research design, after which a description of the research setting is presented. The instruments and data collection procedures are then described, followed by a description of the study participants, ethical consideration and clearance.

3.1 Study design

To reach the aim of this study it was considered most appropriate to use qualitiatve research methods. Qualitative methods are especially valuable in understanding, describing and giving meaning to life experiences (Kazdin, 2003; Burns & Grove, 2009). Qualitative research can result in research findings that describe local customs or views which can aid in successful intervention development (Creswell, 2008). Therefore, the use of a descriptive qualitative method was employed to investigate participants' experiences of challenges associated with family and societal reintegration post psychiatric treatment in order to inform interventions to promote the successful reintegration of MHCUs as well as local conditions which could be used to remedy or support the transition process.

3.2 Research Setting

The setting for the study was the Accra Psychiatric Hospital. The Accra Psychiatric Hospital is one of the three Psychiatric Hospitals in Ghana. It consists of: female,

male, infirmary, geriatric, children and criminal (special) wards and an outpatient department. Staff of the hospital includes psychiatrists, nurses, psychologists and occupational therapists. Participants were recruited from the outpatient unit of the psychiatric hospital as well as the male and female wards.

3.3 Participants

The study population consisted of MHCUs who have received treatment and have been discharged from the Accra Psychiatric Hospital. These MHCUs have remained living within the grounds of hospital even though they have been discharged. Participants included adults of both genders.

Inclusion Criteria

The following inclusion criteria applied:

- Over 18 years of age;
- Had a discharge experience (received the appropriate treatment for a chronic mental health disorder and discharged based on the psychiatrist's review);
- No set abode/homeless (remained living on the hospital grounds or in the immediate vicinity after discharge for longer than one month);
- Awareness of their diagnosis and why they were admitted for psychiatric care
- Provided informed consent (participants must be willing to provide informed consent to participate in the study); and
- Willing to fill the questionnaire as truthfully as possible.

Exclusion Criteria

MHCUs who were floridly psychotic were excluded. A person living on the streets but was not previously been diagnosed with any mental disorder nor been admitted and discharged from the hospital was also excluded.

3.4 Sampling procedure

Purposive sampling was used to select participants who had an experience of self-reported mental illness, homelessness and challenges with reintegration (as indicated by remaining living in the hospital precinct post discharge). Using participants who met the inclusion criteria, this sampling method allowed the selection of appropriate sample based on prior information (Atindanbila, 2013). Prior information in this case was the need to exclude those who were floridly psychotic and included those who were able to participate and provide data. To explain this further, the patients sampled were those who could speak and understand spoken language and as a result provide information about their experiences.

3.5 Sample size

Cormack (2000) proposes that qualitative researchers use a small selective sample, owing to the thorough nature of the study and the analysis of data required. Therefore, a sample of 15 participants was interviewed till the point of thematic saturation was achieved.

3.6 Data collection and management

Procedure

After obtaining both ethical approval from the Human Research Ethics Committee Human Research Ethics Committee of Stellenbosch University, South Africa and Ghana Health Service (GHS) Ethical Review Committee for local (country), letters detailing the purpose and procedure of the study were submitted to authorities of the Accra Psychiatric Hospital for their assistance and permission to be granted for the research. The Hospital Director was approached in writing and provided with full written documentation about the study, including the opportunity to contact the research supervisor for any necessary further discussions. Further discussions were held with the director and other administrative staff whose assistance was judged as significant to the data collection process.

Following agreement to cooperate with the researcher, heads of the various wards assisted in the recruitment of research participants. They were asked to assist with identifying participants based on their mental health history, duration of stay at the hospital and date of discharge. They recruited the participants based on assessment against the inclusion and exclusion criteria. Those who met the inclusion criteria were then approached by the researcher and invited to participate in the study. Since, having the heads invite the patients to meet the researcher might make the patients feel compelled to participate; they were told that they are not obligated in any way to agree to participate.

After agreeing to participate, each participant was given an informed consent form (Appendix C) detailing aims of the study, procedure, what participation entailed,

confidentiality, benefits, and their rights as participants. The form contained phone numbers and email addresses of the researcher to allow participants to clarify any queries. Those who could not read and or understand the English were given the Akan translated version of the informed consent form. They read, signed and returned the informed consent to the researcher before the interviews begun. For participants who could not read, the informed consent forms were read out in the languages they understood.

In recognition of the vulnerability of the participants involved, obtaining informed consent was considered paramount. As such the informed consent form was written in simple and easy to understand sentences. It was also clearly explained to participants in the consent forms that they would not receive better or preferential treatment based on their participation or refusal. All participants were assured that participation in the study is voluntary and refusal to participate will not be held against them. They were informed that they might withdraw from the study at any time without any harmful consequences.

The interviews were then done by the researcher (a clinical psychologist) after obtaining consent from the participant. Responses were audio-recorded with permission from the participant. This was done to ascertain an accurate account of the interview, for analytic purposes. To ensure anonymity during the course of the recording, unique codes were generated to identify the participants. The code was assigned after each interview. It contained information on the gender and date of interview which also allowed for easy tracking. The interviewing process was carried out in a private consulting room at the Occupational therapy unit of the Accra

Psychiatric Hospital where confidentiality of information and privacy had maximum assurance. This venue served as a neutral ground for both the researcher and respondent. This was important to minimize the possibility of the participant assuming that they were attending a therapy session. Participants were again reminded of their right to withdraw from the study or terminate the interview at any time prior to the start of the interviewing session. The researcher sought clarification on any issues at the time of interviewing.

Due to the nature of the living arrangements of the participants, the interviews were conducted soon after informed consent was given. However, in some cases interviewing was scheduled for a later time after recruitment. On other occasions the interviewer required further information on some of the response from some of the interviewees so the interviews were continued at a later stage. This means that not all interviews were completed over a single sitting.

Data storage

The allocated study number was the only identifying information that was entered into the database. As a result, the list linking study participant numbers to names, the audio recordings and transcriptions, was kept in a separate, password-protected file on a laptop computer. Audio recordings were also kept anonymous and audio recordings were stored in a locked file cabinet in the Research Room of the Department of Psychiatry of the University of Ghana School of Medicine and Dental Surgery. Identifying data were omitted from study notes and transcriptions, and these documents were kept in a locked office that is only accessible to the researchers. After the data were analyzed and the results were reported, all study data will be

archived for five years and then destroyed or deleted when it is ascertained that the data will no longer be needed.

Instrument

Qualitative methods were employed to gather and analyse data. This involved interviewing participants using open-ended and semi-structured in-depth interviews (Polit & Beck, 2008). The open ended structure of interviewing allows participants to discuss their opinions, views and experiences fully in detail as opposed to the close ended style which restricts the interview to a set of closed ended questions (Polit et al., 2008). The close-ended style may not allow participants to fully express their opinions and feelings. Face-to-face semi-structured interviews allow for observation and note any non-verbal communication and seek any necessary clarification (Rubin &Rubin, 2005). A semi-structured interview guide was prepared to guide the interviews (Appendix B) (Polit et al., 2008). The interview guide was generated around the research question and aims and based on literature review on discharge and reintegration of MHCUs following inpatient admission for treatment. It also contained themes arising from consultation with providers and users of mental health services (Turner, 2010).

Prior to the start of the semi-structured interview, demographic forms were completed for each participant. The demographic forms were filled on behalf of those who could not fill it themselves. Each interview session lasted between 45 to 60 minutes.

Triangulation of data

Data triangulation involves the utilization of diverse sources of data to approach the same subject matter. Notes were taken during interviews, as required. Documentary review of clinical history and records were used as source of information on referral, diagnosis, treatment received and discharge information. Permission to access these records was granted by participants.

3.7 Data analysis method

The purpose of data analysis is to organize, provide structure to, and elicit meaning from research data (Polit et al., 2008). Specifically, Qualitative Data Analysis (QDA) entails a range of processes and procedures that involves moving from the qualitative data that has been collected to some form of explanation, understanding or interpretation of the people and situations under investigation (Arifen & Yusof, 2012). Many approaches have been suggested in qualitative analysis of data, however the Framework Analysis, which has very specific steps, was adopted for this study. Framework Analysis was used for a number of reasons, including its suitability for working with data from a non-heterogenous set of participants and specific focus on a narrow research question, and because of its flexibility (in that it allows either data analysis to happen at the same time as ongoing data collection) (Srivastava & Thomson, 2009). The Framework Approach also provided structure, aided labeling and helped in defining the data. The stages below were adapted from the article by Gale Heath, Cameron, Rashid and Redwood (2013).

Stage 1: Transcription. In this study, the data analysis process was an ongoing one, beginning as soon as the first interview was conducted. Each audio recording was

thoroughly played (listened to) and after each recording and the researcher did the verbatim transcription of the recording and analysis of the transcripts. The researcher transcribed (self-transcribing) each audio and this process allowed for greater immersion with the material and identification to the point of saturation of the data. Immersion with the data served as a way to ensure that interpretation is not compromised (Holloway & Wheeler, 2002 & Polit et al., 2008). Indeed, immersion and in-depth thematic saturation was attained by the researcher reading and cross reading each transcript thoroughly and multiple times for the purpose of identifying themes within the texts. This was also necessary because it helped ensure that all recurrent information and variations were not missed.

Stage 2: Familiarization with the interview. In order to ensure familiarity with the data, the researcher listened to all parts of each audio recording to ensure adequate familiarization. Stage two of the Framework Approach was done concurrently with stage one.

Stage 3: Coding. The coding process involved two sets of organized note taking of the transcribed data. Thus, when doing the initial coding, notes were kept on the ideas that come to mind to think through or consider and secondly, notes were also kept on emerging themes. These served as an ongoing collection of the researcher's understanding and thoughts regarding content in the text, which gradually aided in the process of building a model (Corbin & Strauss, 2008). After thoroughly reading and going over every line in the transcript; a rephrase, translation or label (a 'code') that best captures the content was written or applied against it. Thus, text segments were identified and its meaning interpreted by allocating a code to it. In this regard, a

coding team comprising of one other researcher; who was specifically hired to code the data and the researcher each separately engaged in generating codes from the first transcripts. The team afterwards, together looked for comparison of similarities and divergences in themes. This process prevented the situation where only one specific perspective took precedence, ensuring that other views were presented. Even though coding can also be done digitally, in this study the initial steps of coding with a paper and pen.

Stage 4: Developing a working analytical framework. As indicated earlier, after coding the first few (six) transcripts, the researchers met to compare the labels and agree on a set of codes to apply to all subsequent transcripts after calculating an agreement indicator codes which were then grouped together into categories to provide a clear definition of the categories. Subsequent coding of the remain nine (9) transcripts were coded by the researcher alone and it was based on the code identified and agreed on earlier. These categories formed the 'working analytical framework'. Additional categories were added to the framework as further interviews were coded.

Stage 5: Applying the analytical framework. The framework was then used to code subsequent interviews. This was done on the Atlas ti Software by the researcher alone to allow for easy storage and organization of the data thereby making retrieval and accessibility of the data less complicated.

Stage 6: Charting data into the framework matrix. Once coding was completed, it was reduced using a process called charting. Charting involves entering data on to a spreadsheet in order to summarize each interview by category in a matrix format. The

major task at this stage was to ensure that the data is reduced while at same time bearing the original meanings and contents of the interview (Sandelowski & Barroso, 2003). As matrices involved putting the data in a table of rows and columns allowing for both cross-case as well as sorting data by the themes identified. Participants are sorted by row and while themes were loaded in columns of the matrix. For each intersection (participant * theme), their themes were summarized (Kandyw (2011). This was also done as it related to the ecological framework/model.

Stage 7: Interpreting the data. The researcher then examined the characteristics of the data and the similarities and differences between data that had been collected. This led to developing links between categories or relationships to explore relationships and/or causality. The data were summarized which involved presenting a model or framework on how the different themes fit in relationship with each other. Tree diagrams showing the relationships between the themes, related codes and the overall study question were produced (See Tree Diagram under Chapter Five). From these, a model explaining the phenomenon of homelessness and reintegration among this group was developed using the themes and their relationship.

3.8 Ethical considerations

The study was conducted in strict accordance with the Declaration of Helsinki (World Medical Association, 2013), which served as the benchmark for ethical considerations in the study.

Vulnerable population

The experience of psychiatric illness, homelessness and reintegration challenges increases the vulnerability of participants in this research. This vulnerability is not only due to their history of mental illness but also their challenges that come with living within a restrictive facility (Eldridge, Johnson, Brems & Corey, 2011). A diagnosis of mental illness may affect one's judgment of circumstance such as commitment or consent to participate in a research. Considering their state, they may likely possess limited reading; writing and comprehension skills in the English language and these deficits may impact their ability to understand the process of research (Eldridge et al., 2011).

Additionally, given their conditions of care they tend to perceive members of staff or researchers as people in authority and as such may not be inclined to disagree with them on participating in a study (Karlberg & Speers, 2010). Thus in recognition of these intricate vulnerabilities the following ethical considerations were strictly adhered to in order to ensure that their rights as participants; irrespective of their mental health and accommodation statuses are not violated or compromised.

Capacity to consent

Owing to the vulnerability of the participants as indicated earlier the procedure outlined by Eldridge, Johnson, Brems & Corey, (2011) was followed in an effort to assess their capacity to give consent**.**

The assessment of capacity started with the researcher reviewing the informed consent form with the participant in the regular manner used in obtaining consent.

The simplified study consent form approved by the IRB, was used as a guide, to reiterate and remind participants of the salient points. After this, the participant was asked explain the main ideas of the study. Those include: participation is voluntary, study procedures, risks and benefits. Based on this process, the researcher (a clinical psychologist) made the final judgment about capacity for consent.

At all times, on an ongoing basis, the researcher considered whether or not the participant had "made a choice" to participate based on their ongoing willingness to participate or not.

Voluntary participation

Written informed consent was obtained from each participant and the voluntary nature of the study was clearly explained. Respondents were informed that they have the right to decide whether they want to be in this study or not. Their participation was entirely voluntary and they were free to decide not to participate.

Confidentiality

Research participants were assured that all information obtained during the course of the study would be kept strictly confidential.

Participant incentives

Participants were given a packed lunch and some snacks to nourish them for their effort in the study. They also received University of Ghana embossed pens.

3.9 Scientific Integrity of the Study

Scientific integrity has been upheld and by conducting and reporting the findings of this study in all manner of honesty. In that disposition, the researcher did not "fabricate data or falsify research materials, procedures or processes undertaken" during the study as Burns and Grove (2005, p.8) cautioned. The responses of the respondents were reported just the way they said it. Furthermore, plagiarism has been avoided by appropriately citing all references alluded to, other peoples' ideas, research processes and procedures, results and conclusions" as is required of all genuine scientific papers (Burns et al., 2005 p.8).

In terms of robustness of data collection and analysis, the researcher employed methods to enhance the credibility, dependability, confirmability and transferability of the study (Forero et al., 2018). Credibility refers to the believability of the results. The researcher has deep familiarity and ongoing engagement with the study setting, and designed appropriate and acceptable data collection tools for the research questions and participants. Dependability refers to the extent to which the result would be repeated by other researchers using the same methods in the same site. This was achieved through thorough description of study methods, and the use of double coding of data. Confirmability refers to the extent to which the results would be corroborated by other researchers. In order to achieve this, the researcher took notes and used documentary analysis to gather additional data included in the results. Finally, transferability refers to representativeness of the data. For this, the researcher ensured that there were no additional codes being added in later interviews (i.e. that data saturation had been reached) before ending recruitment.

CHAPTER FOUR

RESULTS

4.1 Introduction

The results of the present study are presented in two parts. The first section (4.2) presents data on the demographics of respondents of the study and are presented in tables. The second section of the results (4.3), describes the themes and sub-themes that were identified after careful scrutiny of interview data and rigorous qualitative analysis. This is followed by a conceptual model based on study results and a summary of the findings.

4.2 Demographic and details of respondents

In all, fifteen (15) MHCUs (7 males and 8 females) participated in the study. Respondents were aged between 21 and 69 years, with a mean age of 46.6 years (SD = 14.9). From their hospital records, male participants' diagnoses included schizophrenia (n=3), substance use disorder (n=1) and substance induced psychosis (n = 3). Among the female respondents, diagnoses included schizophrenia (n=6) and bipolar disorder (n=2).

Upon inquiring from the staff reasons for the participants' continued stay at the hospital, it was ascertained that they were expecting the families of the MHCUs to collect them from the hospital, refused to leave, and/or did not have any other place to go. Some participants had been previously admitted to Pantang and Ankaful Hospitals. It was also gathered from their hospital records that some participants had

in and discharged from the hospitals for about four (4) or eight (8) times, suggesting they had been admitted and discharged that many times. Some participants had been discharged one or more years while others had been discharged between 3 – 6 months prior to the period of interviewing them for the study. These and information relating to onset of illness, year of onset and previous hospitalizations are presented in Table 2.

Table 1: Demographic characteristics of participants (N=15)

Variable	Frequency
Age (Mean/SD)	46.6 (14.76)
Gender	
Male	7
Female	8
Religion	
Christian	10
Muslim	5
Diagnosis	
Schizophrenia	9
Bipolar Affective Disorder	2
Substance use disorder	1
Substance induced psychosis	3
Admitting ward prior to discharge	
Female acute	3
Female ward 2	3

Female Geriatics	2
Male ward 1	3
Male ward 2	4

Table 2: Documentary clinical/hospital records of participants (N=15)

	Age	Gender	Marital status	No. of Children	Level of Education	Occupation	Diagnosis	Onset of illness (years)	Year of initial admission	Discharge prior to interview	No. of previous admissions	Previous admission	Reason for staying
R1	25	F	Single	0	Senior high	Petty trading	Schizophrenia	7	2015	> 3mth	0	Nil	Waiting for family
R2	31	F	Separated	0	Nil	Self employed	Schizophrenia	13	2007	>1yr	3	Nil	Waiting for family
R3	52	M	Single	0	Tertiary	Finance	Schizophrenia	34	2001	>1yr	5	Nil	Waiting for family
R4	57	M	Married	5	Senior high	Self employed	Schizophrenia	17	2015	> 6mths	4	Pantang hospital	Lost contact with family
R5	68	F	Married	0	Senior high	Petty trading	Schizophrenia	28	1988	>1yr	1	Ankaful	Client refusal to leave
R6	52	F	Separated	3	Junior high	Petty trading	Schizophrenia	25	2001	>1yr	7	Nil	Client refusal to leave
R7	48	F	Separated	2	Tertiary	Health	Schizophrenia	23	2013	> 3mth	5	Pantang hospital	Waiting for family
R8	30	M	Married	3	Primary	Petty trading	Schizophrenia	7	2012	> 6mths	2	Nil	Waiting for family
R9	42	F	Married	2	Senior high	Self employed	Biploar affective disorder	8	2011	>1yr	4	Nil	Client refusal to leave

	Age	Gender	Marital status	No. of Children	Level of Education	Occupation	Diagnosis	Onset of illness (years)	Year of initial admission	Discharge prior to interview	No. of previous admissions	Previous admission	Reason for staying
R10	69	M	Widowed	1	Senior high	Artisan	Substance use disorder	27	2001	>1yr	7	Pantang hospital	Client refusal to leave
R11	56	F	Single	2	Junior high	Petty trading	Schizophrenia	35	2012	>1yr	8	Komfo anokye	Waiting for family
R12	46	F	Married	2	Postgraduate	Finance	Biploar affective disorder	10	2014	>1yr	2	Nil	Client refusal to leave
R13	21	M	Single	0	Junior high	Unemployed	Substance induced psychosis	7	2011	>1yr	4	Nil	Waiting for family
R14	34	M	Single	0	Senior high	Unemployed	Substance induced psychosis	20	2012	>1yr	4	Nil	No where to go
R15	38	M	Single	0	Senior high	Self employed	Substance induced psychosis	20	2010	>1yr	3	Nil	No where to go

4.3 Qualitative data analysis

After rigorous analysis of data, four (4) major themes and twelve (12) sub-themes were identified relating to social reintegration and experiences of homelessness in the context of discharge from the psychiatric hospital.

The first major theme was *Individual factors* and the sub-themes: *sense of worth/belongingness* and *concerns for health/wellbeing after discharge* were employed to explain the major theme. The second major theme was *family factors* and the sub-themes: *the lack of acceptance or exclusion from family*, *marginalization from family*, *stigmatizing beliefs and misconceptions of mental illness* as well as *financial constraints* were used to explain the second major theme. The third theme was *Community factors* with subthemes – *stigma, general misconceptions about mental illness* and *marginalization* were found to promote homelessness and impede successful reintegration. Finally, the theme *institutional factors,* was explained using the sub-themes: *poor discharge procedures, lack of proximal mental health facility and service* as well as *material benefits from the psychiatric hospital*.

Individual factors

This theme examined factors that were individual factors relating to respondents of the study. It explored personal influences that made it less likely for respondents to return back into the "outside world".

Sense of worth and belongingness

This sub-theme observed that MHCUs reported experiencing a sense of belongingness and worth in the Accra Psychiatric Hospital that they were not getting from outside the hospital environment. This was a factor affecting their reintegration. Extracts to support the above assertions are provided below

"I enjoy being here, they allow me to go in and out of the ward to buy things for staff, they let me handle the keys to the ward, I get to assist nurses bring food into the ward for other patients…meanwhile at home nobody even notices me." (Respondent 4)

"Nurses and doctors talk to me in a nice manner, they understand me and I like that. The other day some students and white people came here and they sat with me and chatted. Nurses also let me go and collect food for the other patients on the ward and I control the TV remote."

(Respondent 9)

"Somehow, I help the new patients cope. I also make some money because I'm one of the people who lock the gate of our ward. Their family members sometimes leave money with me."

(Respondent10)

It was evident that the care offered by the hospital to the MHCUs was a significant factor influencing their continued stay in the hospital. MHCUs who remain in the psychiatric hospital after discharge report that they enjoy this feeling of care and belonging, as well as feel a sense of security as their nutritional, medical and other physical needs are taken care of, which may not be the case in their families' homes.

Concerns for health/wellbeing after discharge

Some respondents noted that there were particular concerns that they had that were contributing to them not re-entering society. They reported that they did not leave the hospital precinct because they feared a re-occurrence of their illness once they left the hospital. The majority of respondents (n=9) were anxious that an episode might occur once they left the hospital grounds. Due to this fact, some of these participants expressed a desire to remain in the psychiatric unit rather than be reintegrated in to their families and communities. Below are extracts to support the sub-theme.

"The only danger that I envisage is that maybe if I leave the hospital the illness might come again because several times when I go to the churches and shrines, I don't experience it until I go back home." (Respondent 1)

"…it is better just to stay here where they can always help when I have a problem…"(Respondent 1)

Although these are individual level factors, they specifically link with the broader institutional and care system issues which are described further below. Specifically, the lack of ongoing support and treatment via community-based services, is a major contributor to this issue.

Family Factors

The family factors theme, examined factors external to the MHCU that affected reintegration into society. The sub-themes *lack of will or readiness to receive them, marginalization from family, financial constraints* and *family stigmatizing beliefs and misconceptions of mental illness* were employed to explain this theme.

Lack of will or readiness to receive them

Respondents commonly talked of the lack of acceptance and experiences of exclusion by the family toward MHCUs who had been discharged. It appears that the intentional "dumping" of MHCUs at the hospital was common and respondents felt that it showed that their families did not accept them. Find below some extracts that support the above assertion:

"I am waiting for my sisters to come and get me. I am waiting on transportation back home. " (Respondent 3)

"…I'm waiting for my mother to come. When they called her she told them that she wants me to spend the Christmas here and then she will pick me up. After the Christmas she also then gave an excuse that she was sick and was admission at a hospital and that she will come. So, after I waited and noticed she wasn't coming, I run away and went home. She brought me back here in January. We are in September now but she still hasn't come. She just isn't ready to have me back…" (Respondent 4)

"They, I mean my aunties, said they're fixing my room. They said there was a fire about 2years ago and my room was burnt so they're putting it back together. When they're done they'll come for me." (Respondent 14)

The extracts above that while respondents appear to want to return to live with their families, families are not always willing to take them back. Some respondents said their families were waiting for resources (such as transportation fare or preparing a place where the MHCU could stay), but sometimes reasons for the unwillingness of families members to fetch the participants were not clear. It appeared that the same lack of post-discharge support that individuals require but are not accessing, is also lacking for families, who may not be equipped to take on a family member with ongoing health problems.

Marginalization from Family

Several respondents talked of their being marginalized by family and friends and how this influenced their ability to reintegrate with their families and return to their homes. Below are extracts of the responses from the MHCU to support the point on stigma or marginalization.

"…Nobody wants to be married to a mad woman. I was not like this and [my husband] was not like this. I haven't even seen him in the past 10 years so I am not sure I am still married. I haven't even slept with him for over 11years…" (Respondent 2)

"…look, I'm miserable. I am desperate. They don't seem to understand. Help me, please…" (Respondent 7)

"My younger sister doesn't even think that I can work. How dare she! She prevented me from opening my own salon... she fears my symptoms come when I'm working. So I depend on her" (Respondent 12)

"My stepmother said I should forget about ever coming back home." (Respondent14)

"*My auntie and cousin said they don't ever want to see me again*". (Respondent 13)

Most MHCU reported feeling marginalized by even their own families and other close members of society. Family members seem to create an impression to the MHCUs that they may not be comfortable having them around or including them in married or family life. This is linked to the notion that they should stay away, and not return from the hospital. This issue of marginalization affects reintegration and encourages their continued stay in the hospital.

Financial constraints

This was another sub-theme that was observed under the social factors that makes it difficult for reintegration and thereby perpetuating homelessness. Financial constraints on the part of family and friends can make it difficult for them to visit and to pay for MHCUs medical bills and medication, which also contributes to the barriers to reintegration. Find supporting extracts below:

"…my brother keeps complaining that, my medications are too expensive and that I have become a burden on him because he takes care of my parents as well as me…" (Respondent 12)

"…the last time my husband was here, he told me he had to borrow money to come here and pay for my medicines and my treatment at the hospital. After that I haven't heard from him again and I feel it's because I have become a burden on him…" (Respondent 5)

"… My father has to come because I owe some money here. The other ones they came to leave some money with the nurses here. And I sometimes had some left so they will give it to me when I'm discharged to pay my lorry fare. But not this time, I don't have any money here. There is a

fee we pay here after which you will be discharged and this time around they failed to ask my father for this money and so it has become very problematic for me…" (Respondent 4).

The extracts above give some evidence for the fact that there are financial barriers at family level which appear to be a hindering factor to reintegration and consequently increasing the likelihood that discharged patients are remaining at the hospital instead of returning home.

Family stigmatizing beliefs and misconceptions of mental illness

Linked to the above, many respondents noted stigmatizing attitudes about mental illnesss contribute to the breakdown of their relationships with their families. Extracts to support this sub-theme are as follows:

"… sometimes I hear people say that if others use the utensils I use, they may also behave like me [mental illness] meanwhile I know that this illness is not like cholera..." (Respondent 1)

"…. they get angry when I go to the psychiatric hospital. They say that this thing has a spiritual cause and as such I need a spiritual healing that the hospital cannot provide" (- Respondent 11)

"…my family members have taken me to several pastors and fetish priests because the say my illness is not normal" (-Respondent 3)

The above provides evidence that the perception of families towards MHCU also make it difficult for them to be reintegrated into society. Family stigmatizing beliefs and misconceptions (such as mental illness is contagious) appear to be very demeaning for MHCUs. Also, respondents report that the idea that mental illness has a spiritual or demonic connotation means

that there is an element of fear on the part of families which makes it hard for them to accept them and reintegrate them into the family.

Community Factors

Stigma

Respondents also discussed stigma as an issue within the broader community, not just within their families. Respondents were of the opinion that they were seen and treated differently by others and that in itself is a reason why they continue to be at the psychiatric facility even after discharge. Find below extracts to support this sub-theme.

"… [they] laugh at me. They know that is it is spiritual … but sometimes they say I have been cursed so something like that. Sometimes too they say my behaviour is intentional. So the treatment is sometimes pity…" (Respondent 1)

"… Some people who are not my friends said bad things about me. They said it was punishment because my husband did not marry the woman he promised marriage to. Some people too said it was punishment because my father had raped somebody…" (Respondent 2)

It can be realized from the above excerpts that MHCUs suffer from stigma in a variety of ways. They are objects of mockery and scorn. Others in the society see them as misfits who are being punished for their errors or errors of relatives.

On another level, the issue of stigma is evident from the accounts of respondents in the form of marginalization. Find below extracts to support this.

"…With regard to friends and other relations sometimes when we are chatting, they think that because am a mental patient, when I speak about things that are important they don't regard it as important. They don't consider me as a very important person. They don't consult me on family issues. People don't even leave their children with me. Sometimes some people are even afraid to eat from the same bowl with me. I can remember that a certain boy didn't want to use a cup because I had used it…" (Respondent1).

"…for example, the other day, when I had been discharged, my mother and small brother were discussing an issue. As soon as I shared my opinion, my small brother started laughing as if what I said did not make sense, I felt so bad" (Respondent 8)

"…there is no respect for me outside the hospital even in my own family. You see I am a mechanic and I have been having small problems sometimes which bring me to this hospital. Can you believe that when my father died and they were making the funeral arrangements and when it got to contributions, I brought my portion and the family elders said it wasn't necessary…I wondered why then realized it was because I was a mentally ill person"… (Respondent 15)

The extracts above indicate that, community members who know about the previous mental health condition of MHCUs marginalize them in their dealings with them.

Misconceptions about mental illness

From the framework analysis of data, it became evident that community members have poor knowledge and perception about mental health conditions which has contributed to homelessness and impeded successful reintegration. Below are excerpts of the responses from the MHCUs:

"... They accept me how they have been doing; [they always] see me as mad. I am not expecting anything different. They don't know any better" (Respondent 1)

"... I will like people to understand that it is an illness. No need to keep chaining or beating me up like it happened in the prayer camp...." (Respondent 14)

"... They don't understand my sickness..." (Respondent 12)

Service-related Factors

The last major theme looks at how the problem of reintegration and homelessness are linked to factors that are specific to the Accra Psychiatric Hospital and by extension mental health service delivery in Ghana. Three sub-themes were used here to explain the major theme; poor admission and discharge procedures, lack of community mental health services and the material benefit of staying in the hospital.

Poor admission and discharge procedures

The process and period of transitioning from prolonged hospitalization at a psychiatric hospital back to society can have significant implications for one's lifestyle. For some of the respondents, though they were judged physically fit to return home, they did not feel psychologically adequate to handle the life outside the institutionalized psychiatric care. This in their opinion culminates in their returning to hospital after previous discharges. This is supported in these extracts.

"… So they came on ward rounds and the nurses recommended me to my doctor that she thinks I am better so I should be discharged to go back home…and so the doctor reviewed and said I have been discharged so I should wait for the social welfare woman to come so that she can put in on a vehicle back home [This is what happens]. But my people at home have not been told. So after the ward rounds I went to see my doctor in his office and told him that I want to stay a little because I was not ready to go back home, yet. He agreed and wrote a note for me to bring back to the nurses. That is why I'm still [here]. I'm not ready and my house people too are not ready…" (Respondent11)

"… Sometimes, when I go back home my room will not be available. So, I will fight with them because they have messed up my room and my things. I once used the pestle to hit someone because they were arguing with me. They don't understand my sickness. Before, I'm told to go home, the (staff) should tell them that the medicine I take makes me eat a lot so they must give me… when I ask for food because of my medicine, they don't give me. So I end up not taking the medicine at all because don't I want to be hungry. And then when the sickness come they bring me back..." (Respondent 12)

"When my husband came the nurses told him that I have been discharged so he should pay the bills and take me home. He did that but the following day he brought me back to see another doctor in this same hospital but didn't say I was just discharged and that doctor admitted me again to another ward. If they had a good system they will know that I was discharged from here only yesterday. But he's the man..." (Respondent 12)

From the excerpts above, it can be realized that, failure of the staff of the psychiatric hospital to communicate discharge procedures effectively with MHCUs and their families serves as a basis

for homelessness and a hindrance to reintegration. Again, poor discharge systems allow for readmission of MHCUs without verification.

Lack of community mental health services

From the analysis of data, it became evident that the lack of accessible community-based mental health institutions for MHCUs serves as a barrier to reintegration. Below are excerpts of the responses:

"…There is no mental hospital so close to my place so all the places I have been taken to are shrines and church houses. … when I later go home, I don't have any nearby hospital to go for my drugs" (Respondent 1)

"… There's no psychiatric close to where I come from…but one nurse used to come home to give me injections. But she stopped coming. She used to come every month. That is why I have to come all the way here… to Accra…'. (Respondent 11)

On the other hand, one respondent noted that she preferred to come away as she felt like local service providers would tell community members about her illness and she preferred for them not to know.

"… a nurse used to come and give me medication when I came from London so people didn't know. But she stopped and another nurse used to come. I suspect she told other people on my streets about my illness. So, I have to come all the way here. But I wish this place was not called Asylum or psychiatric hospital. Maybe a Mental Wellness Centre..." (Respondent 7)

It is clear that the lack of accessible community-based services means that MHCU are not able to access appropriate care and support when they return to their communities. It is also possible that the community-based services that do exist are not functioning well and the same standards are not being upheld as they would be in the larger hospital. This is likely to be contributing to individual's reluctance to leave the hospital precinct, as well as families' willingness to take their family members back in to their homes.

Material Benefits from the Psychiatric Hospital

On the other hand, some participants spoke of the benefits that they receive from the hospital as being one of the reasons for their continued stay in this hospital. The excerpts below support this:

"They give us medicine in the morning and in the evening. They also give us clothes and slippers. … they are taking care of us and they give us food three times a day. I don't give them any money." (Respondent 2)

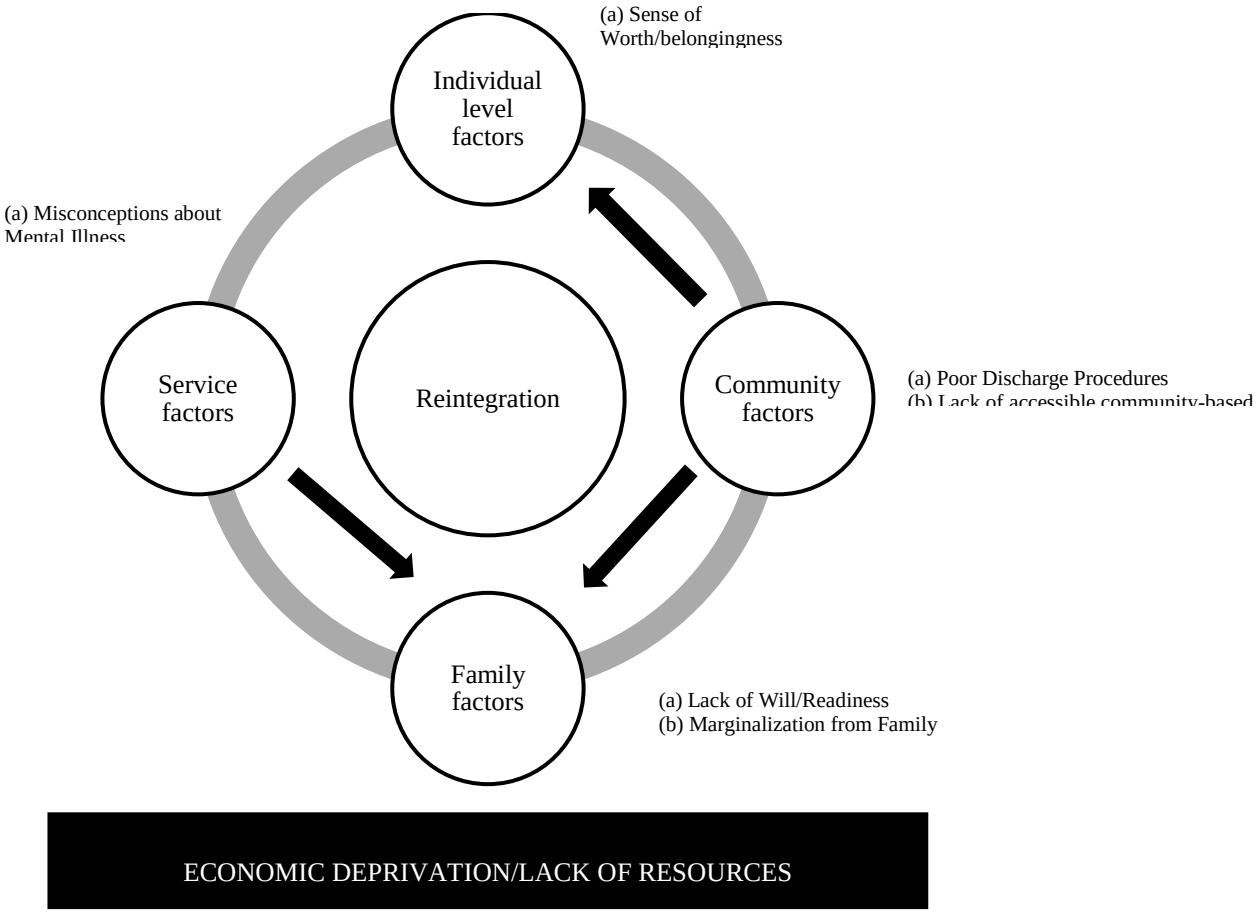
"We have TV on our ward so I can watch it. The medication I get here is free" (Respondent 2)

4.4 Conceptual Model Based on Findings

Thus, the reasons for participants' prolonged stay in the hospital or hospital grounds are complex, and reflect a range of factors at individual, family, community and service level. Each of these factors influences the likelihood or capacity for MHCU to leave the hospital and return and reintegrate into their homes and communities. In addition, there are also influences between different levels. For example, the lack of community-based services or discharge preparation and information for families puts pressure on families, who in turn are more likely to reject or

marginalise their family member. In Figure 3, below, some of these complex relationships are captured.

Figure 2: Conceptual Model



4.5 Summary of Findings

From Figure 2 above, it can be clearly observed that there are four major levels of factors that influence reintegration and ongoing homelessness of MHCU who are living in and around the hospital post-discharge.

The four major factors include those pertaining to the individual, family, community and mental health services. At individual level, feelings of self-worth that are nurtured within the hospital environment but not experienced at home mean that MHCU can be reluctant to leave. Adding to this, fear for the future, particularly around relapse, also contributes to this reluctance. These personal feelings are very much shaped by factors at the other levels. For example, families and communities could nurture and care for people with mental illnesses, particularly if issues at the service level were addressed. Although superficially separate, service-level issues are actually closely linked with the possibility for relapse and fear of lack of support and help managing their illness once MHCU return home. Family factors are also influenced by factors at different levels. Data showed a lack of will or readiness on the part of family to take back their family member, marginalization of MHCU within families, stigmatizing beliefs and misconceptions of mental illness within families, as well as financial constraints to supporting MHCU when they return home. Family and community-level stigma are likely to be closely linked. In addition, families are not accessing their own forms of support and discharge planning from mental health care services to assist them to take back family members, particularly against the context of limited resources. A lack of accessible community-based mental health programmes to assist with management and support in the long term is also contributing to the pressures on the family. This is also evident in the theme relating to the benefits of remaining in hospital, which links strongly

to material benefits which may be crucial for well-being in the context of poverty. Finally, all of these findings should be considered against the context of economic deprivation and lack of family and community resources alluded to in the interviews.

CHAPTER FIVE

DISCUSSION

This study investigated the experiences of social reintegration and homelessness among MHCUs who have been treated and discharged from the Accra Psychiatric Hospital, but who remain living with the hospital grounds. Aims and objectives therefore were to (1) explore perceptions and experiences of MHCUs homelessness after they have been treated and discharged from the Accra Psychiatric Hospital in Ghana; (2) gain an understanding of the challenges MHCUs experience when they attempt to integrate into society when they are discharged from mental hospitals; and (3) explore issues, which may support or be a barrier to reintegration, including family factors (support, resources), mental health history and beliefs around illness and access to mental health services. Using a descriptive qualitative method, 15 MHCUs were purposively sampled and recruited from the Accra Psychiatric Hospital. This included 7 males and 8 females between the ages of 21 and 69 (mean age of 46.6 years).

Framework analysis was used to analyse semi-structured interview data. Four major themes and twelve sub-themes were identified as reasons accounting for MHCU continued stay at the Accra Psychiatric Hospital. The first major theme was *Individual factors* and the sub-themes: *sense of worth/belongingness* and *Concerns for health/wellbeing after discharge* were employed to explain the major theme. The second major theme was *family factors* and the sub-themes: *the lack of will or readiness of family, marginalization from family, stigmatizing beliefs and misconceptions about mental illness* as well as *financial constraints* were used to explain the second major theme. The third theme was *Community factors: general misconceptions about*

mental illness, stigma with *marginalization* were found to promote homelessness and impede successful reintegration. Finally, the theme *service-related factors,* was explained using the sub-themes: *poor discharge procedures, lack of proximal mental health facility and service* as well as *material benefits from the psychiatric hospital* as contributors to homelessness and impediment to successful reintegration. These themes, for the most part, mirror the layers of factors as described in the ecological model influencing an individual's likelihood to be able to socially reintegrate and find appropriate accommodation post-discharge, as laid out in the literature review of this thesis.

Microlevel factors (Individual and Family Factors)

The results showed that, from the MHCU perspective microsystem factors, such as their individual characteristics and experiences, as well as their direct relationships with their family members strongly influenced their perception of whether or not they were able to return home. For the most part, respondents identified barriers to reintegration at this level, as opposed to factors that facilitated reintegration.

Surprisingly, at individual level, MHCU indicated that, to some extent, they were unwilling to leave the hospital because of the protection it afforded them. A number of participants indicated they were treated with respect at the hospital, which contributed to an enhanced sense of self-worth and a feeling that they belonged. The perceived lack of feeling valued to the same degree in their families and communities was also noted. In addition, fear of leaving was also expressed,

in particular due to concerns about their health or wellbeing after discharge from the psychiatric hospital. This was reinforced by the perception that the type of support and care available in the community (discussed further below, in the section on meso system factors) was lacking. This contrasts with findings from Thornicroft et al. (2007) who reported that even among mental health care workers there are negative attitudes towards MHCUs and that this affects their access to care.

At the family level, respondents reported that their family members showed that lack of will or readiness of family and that they felt marginalized by them. Very few MHCU reported that their family members had showed concern about their psychological health. MHCU commonly reported that contact with families reduced nearing or at the point of discharge. These findings contrast with the supportive family environment that Caton et al. (2000) report being important for avoiding homelessness and successfully reintegrating post-discharge.

Caton et al. (2000) specifically identify financial support from family as a key factor supporting reintegration, and this appears to be highly relevant in the Ghana context. Financial constraints were a paramount concern. Most participants reported that family members had difficulty taking them home due to limited financial resources. MHCU also felt that there was a perception by family members that MHCU are not able to hold gainful employment or in be a position to contribute financially to the MHCUs upkeep. Although participants in the study had been discharged they would depend largely on their family members for their basic needs.

At micro level, perceived barriers reflected cost, inconvenience, unpleasantness, and life-style changes (Kozier et al., 2008). In this study, it was observed that some MHCUs and their families have failed to support social reintegration of MHCUs since they perceive that doing so would come at a huge cost and inconvenience. For one thing, most of the MHCUs count on the convenience of free food, shelter, water, with no electricity and water bills while in the hospital unlike the home where they would be required to do all these on their own. The families of the MHCUs are also aware of the challenges they will have if they should accept their relative back home.

The study further indicated that stigmatizing beliefs and misconceptions about mental illness by family members contributed to the phenomenon of homelessness among MHCUs. Most of the participants indicated that their family members had poor understanding; and recounted stigmatizing beliefs and misconceptions about their mental health. According to some MHCUs interviewed, their disorder was viewed as a result of some spirit or past sins of others or past personal sins. Thus, the study found strong support for the findings of Ewhrudjakpor (2010) who reported that one paramount barrier to social reintegration of individuals living with mental illness in Nigeria is their traditional beliefs and myths.

Mesolevel factors (Community and Service-related Factors)

Molodynki et al. (2010) report that discharging patients to homes in the community does not necessarily guarantee reintegration into society. Their findings were echoed in this study, where community-level stigma was also an important concern of MHCU. MHCU reported that community members had strongly stigmatizing reactions to them across different types of

interactions. In turn, this stigma affects the likelihood that they will be able to get and retain employment. In this regard, MHCUs discharged from psychiatric hospitals, reintegrated into communities and prevented from working are much more likely to be re-hospitalized than MHCUs who have employment or engaged in work post discharge (WHO, 2001; Molodynki et al., 2010; Svab, 2012).

The MHCUs also felt that community members had faulty perceptions about them and their capacity, and were not able to see their condition as an illness. These beliefs affected not only them, but their families as well. MHCUs reported that people in the community often believe that mental illness is a result of evil spirits, or linked to the past mistakes of the MHCU or their family. This is likely to further contribute to preventing MHCUs from entering work or returning to their previous employment. As such, families themselves are at risk of being stigmatized or isolated as a result of the link with the MHCU. This finding supports the ecological system theory, which posits that there are interactions among the various levels.

In terms of services, two aspects of mental health service delivery were highlighted by MHCU as barriers to reintegration. Firstly, there was very little information given to MHCU or their families about discharge and how to manage the transition back to the family home. This is one of the most common reasons for people becoming homeless in HIC settings as well (Folsom, 2005, Gaetz, 2010, and Padgett, 2007). A lack of a structured discharge plan was a key factor identified by MHCU. It was evident in this study that some of the MHCU who were judged by the staff as ready to be discharged were not psychologically prepared. This suggests the importance of a bio-psychosocial approach to healthcare and treatment (Knapp, McDaid,

Mossialos & Thornicroft, 2007). A well planned, structured and executed admission and discharge program is essential for recovery. Poorly planned discharges have been identified as one of the greatest problems in the treatment and management of MHCUs (Bonsack et al., 2007). Secondly, MHCU highlighted that they had to travel long distances to receive psychiatric care after discharge. This is because the discharge planning did not seem to consider where these patients lived or how they could benefit from nearby services for MHCUs. Kruger et al. (2011) found that the lack of community care facilities meant that MHCU had to continue to rely on tertiary services for their treatment.

Exosystem factors

These aspects described above relate directly to exosystem factors, such as policies and laws to prioritise and provide community-based services. Yet, although exosystem factors have a substantial impact on MHCU, they were not discussed by the respondents, likely due to their relative distance from the individual level.

Macrosystem factors

Macrosystem factors, particularly resulting from cultural beliefs were identified by MHCU. In theory, the Afrocentric Worldview could help to explain barriers and facilitating factors to reintegration. However, it appears that traditional beliefs about causes of mental health problems had a negative influence on social reintegration, and that families and communities are stigmatizing, marginalizing and even preventing MHCUs from obtaining employment. On the other hand, the cultural values of inclusivity and collectivism did not seem to extend to MHCU.

Recommendations

From the findings, it is evident that preventing homelessness in discharged MHCUs requires the involvement of many interconnected stakeholders to address a complex set of barriers to reintegration.

Treatment facilities should be made easily available and accessible to all who may benefit from it. Government and policy makers should endeavour to make health services for mental disorders easily accessible at various centers in Ghana and not only the Greater Accra, Ashanti and Central regions, providing a mix of service levels, not only tertiary services. Mental health personnel need to ensure that the discharge planning occurs and involves the family of the MHCU. They should be involved in educating family and community members about mental health and mental illness so that they are better informed on the causes, early signs and treatment options available. Education on reintegration should stress the idea that MHCU can and will be capable of maintaining routines, receive vocational training and support to even engage in work activities. These may be useful in promoting a realization that diagnoses of mental disorders should not necessarily signify the end of a productive and meaningful life.

At community level, the Afrocentric worldview theory suggests that Africans have a sense of cooperation, which might make many individuals in the African community, cooperate with advocates of social reintegration. Framing social reintegration in this manner may contribute to a more positive community response, particularly if leaders or respected community members are convinced about such action and actively encouraged to spearhead mental health discussions and education sessions. Hence, collective responsibility might support families to have a sense of

responsibility towards the health their relatives living with mental illness. This means that in advocating for change, these elements would have to be carefully considered and inculcated. It is also essential to educate each MHCU, their families and communities about the *benefits of reintegration.* This would include education and media campaigns about the value or usefulness of a reintegration in decreasing the risk of developing mental disorders.

It could for example be said that, because of this lack of acceptance of MHCUs, people who have certain conditions or problems needing psychiatric/psychological intervention often hide until it becomes unbearable. This recommendation for policy and practice is important because, people lean towards healthier behaviours when they believe the new behaviour will lessen their probabilities of being ill (Kozier et al., 2008). In this regard, if individuals perceive that it is beneficial to socially reintegrate MHCUs into the community, they would most likely support it. Again, if any individual perceives that reintegration and stable accommodation will be more beneficial they will be more willing to adopt it and work towards it.

In advocating reintegration, the findings of this study, suggest a need to look further into perceived barriers to reintegration. Of all the constructs that influence health action, Kozier et al. (2008) for instance advised that “Perceived barriers are the most significant in determining behaviour change.” Psychologists therefore are to be involved in the discharge and public sensitization process to impact the fact that the benefits of the reintegration to the individual, family, community and the nation far exceeds the consequences of maintaining the previous way of stigmatizing, marginalizing, and rejecting their participation in family, work and social affairs.

With these, barriers to reintegration could be overcome so that a new behaviour to good health is adopted.

Suggestions for Further Research

This research focused on the views of the MHCUs so as to understand the factors preventing reintegration of discharged MHCUs into society, in order to best understand the experience of homelessness and barriers to reintegration from their own perspective. However, given the strong representation of family, community and service-related factors, future research should consider the views of the family, community members and mental health personnel. Families and communities could give insight into specific services and support that would be useful for them over the discharge period and on an ongoing basis post-discharge. Mental health staff will have valuable views on how discharge processes could be better managed.

Furthermore, it would be necessary to consider grounded research so as to develop a theory on homelessness and reintegration. The Ecological system model and Afrocentric worldview theory has been useful in explaining homelessness and reintegration. However, since none is fully adequate to explain the phenomenon, a grounded research to tease out a relevant theory would be useful in health promotion in this regard.

Limitations of the Study

In spite of efforts to carry out a study with a number implications for literature, some significant methodological limitations regarding the sample and measures should also be mentioned. Specifically, the sample used in this study did not include participants from all the psychiatric

institutions and hospital in every region of Ghana. Furthermore, the study employed a relatively small sample. Future studies should employ a larger sample size to help in the generalizability of findings. It could also consider including participants from services in smaller cities towns across the country.

Secondly, this study used the perspectives of only MHCUs when investigating homelessness and reintegration. It however appears that homelessness and reintegration is not a restricted experience to the MHCU but also the family, community, and health personnel as a whole. Using only MHCUs therefore, the findings about factors influencing homelessness and hindering reintegration are not a hundred percent conclusive. It would thus be prudent to consider the other human/institutional factors mentioned above.

The use of qualitative designs comes with some critique. Johnson and Onwugbuzie (2004) highlighted that qualitative researches may reflect the researcher's own idiosyncrasies, and that, knowledge gained from such studies cannot be generalized to other settings. However, the substance of this research remains trustworthy because Creswell (2008) argues that quantitative research approaches may arrive at conclusions that do not reflect local conditions due to the focus on theory, as was the case in some literature reviewed. In view of these critiques, well calculated attempts were made to ensure that, the framework analysis had independent raters, and only direct quotes from the MHCUs were used and presented in the findings so as not to mislead any audience to this work. Double-coding was done by two independent researchers to reduce human biases. However, it is also possible that, some interviewers may inadvertently have promoted what Johnson et al. (2004) referred to as whereby, they unconsciously admire

responses that go towards their expectation. Examples of these by the use of certain unassuming cues in verbal interactions – *I really like this point your just made – thank you very for this point – you're the first participant to have made this observation* and so forth.

Conclusion

The success of every society depends on the mental wellbeing of its citizens (Anlimah, 2017). When mental well-being is at risk, such as for individuals with mental health problems, measures should be put in place to help them redevelop a healthy life in their families and communities. Investigation of the experiences of homelessness among MHCUs who have been treated and discharged from the Greater Accra Psychiatric Hospital have yielded a number of useful findings showing that different levels of inter-related individual, family, community, service, societal and culture-related factors influence the process and likelihood of reintegration. These findings largely reflect literature from other, mainly HIC settings. Based on these findings, there are clear steps that governments, communities and health care workers must take to better support MHCU and their families after discharge to protect their mental health and support social reintegration.

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APPENDICES

Appendix A: Stellenbosch University Approval Notice

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Approval Notice
Stipulated documents/requirements

27-Jul-2015
Williams, Beatrice BD

Proposal #: HS1159/2015

Title: **Experiences of homelessness among mental health service users who have been treated and discharged from the Accra Psychiatric Hospital**

Dear Ms Beatrice Williams,

Your **Stipulated documents/requirements** received on **26-May-2015**, was reviewed by members of the **Research Ethics Committee: Human Research (Humanities)** via Expedited review procedures on **27-Jul-2015** and was approved.
Sincerely,

Clarissa Graham
REC Coordinator
Research Ethics Committee: Human Research (Humanities)

Appendix B: Ghana Health Service Ethical Clearance

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com

My Ref. GHS/RDD/ERC/Admin/App/16/136
Your Ref. No.

Beatrice Dwumfour Williams
Department of Psychology
Stellenbosch University

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

GHS-ERC Number	**GHS-ERC 14/05/16**
Project Title	Experiences Of Homelessness among Mental Health Service Users Who Have Been Treated and Discharged from the Greater Accra Psychiatric Hospital
Approval Date	16th August, 2016
Expiry Date	15th August, 2017
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.....
PROFESSOR MOSES AIKINS
(GHS-ERC VICE-CHAIRPERSON)

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

Appendix C: Informed Consent Form

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
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STELLENBOSCH UNIVERSITY

PARTICIPANT INFORMATION SHEET

Experiences of homelessness among MHCUs who have been treated and discharged from the Accra Psychiatric Hospital.

Background Information

Homelessness is a common social problem found to co-occur with mental illness worldwide, and has received intensified attention in the media and the psychiatric literature. Persons with mental illness experience this problem more frequently because they live in a society in which it is rife, and not only because they are mentally ill. Thus, researchers and mental health service providers continue to seek ways that improve services and also address this problem among persons with mental illness.

Introduction

My name is, Beatrice Dwumfour Williams, an MPhil student from the Department of Psychology at Stellenbosch University, South Africa. I am conducting research study on the

experiences of people with mental illnesses who received treatment and have been discharged but at still in the psychiatric hospital. The results will be contributed to research thesis. An interview will be conducted and it will take approximately sixty to ninety minutes.

What is purpose of the study?

I am conducting interviews with key people like you on the experiences of MHCUswhen they leave the psychiatric hospital. The purpose of this study is to gather information that will help us to understand experiences of people who received treatment from the psychiatric hospital and the challenges they face when they are discharged from the hospital and their efforts to integrate back into the community. Since you have received treatment and been discharged but are also leaving in the hospital; you are considered eligible to participate in this study.

I would like your permission to talk with you today about your ideas and experiences related to your experiences since you were discharged.

The funding for this project is from the **AF**rica **F**ocus on **I**ntervention **R**esearch for **M**ental Health **(AFFIRM)** based at the University of Cape Town.

What does giving consent mean?

Consent means agreeing to take part in this study. You have the right to decide whether you want to be in this study or not. It also means, if you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. Your participation is entirely voluntary and

you are free to decide not to participate. Whether or not you choose to be involved in this study is your choice. You do not have to feel forced to participate because the researcher is a clinical psychologist. The interviewer is now in the role of a researcher. No one is forcing you to take part. If you say no, this will not affect you negatively in any way whatsoever. You are also free to change your mind at any point, even if you do agree to take part in the beginning.

The investigator may withdraw you from this research if circumstances arise which warrant doing so. If you become violent or aggressive towards the researcher *the investigator without regard to your consent may terminate your participation.*

What does the study involve?

If you volunteer to participate in this study, we would ask you to do the following things:

Be involved in a one-on-one interview with the researcher. It is estimated that each interview session will last between 60 to 90 minutes.

You will be contacted and asked to attend an appointment at a time that suits you.

Then researcher will interview you and ask for demographic information, such as your age, education, number of children, marital status and employment and what it has been staying in this Hospital even though you have been discharged

What will you be required to do?

If you accept to participate in this study, you will be interviewed about your living arrangements since you were discharged as well as challenges you have faced with reintegrating into the community. The interview will be conducted once, but the researcher may need contact you later for clarification of the conversation if necessary. The interview would be recorded with a tape recorder with your permission. The interview will be carried out in a private consulting room at the Occupational therapy unit. You can ask the interviewer any question at any point during the process if you need further clarification and understanding.

How long will participants stay in the study?

You will be in this study for about on 60-90 minutes.

What potential risks and discomforts are involved?

There is no known risk associated with participating in the study.

It is not expected that any harm, risks or discomfort will come to you through taking part in this study, which involves you speaking to a researcher, and answering questions and being audio recorded. But if experience emotional discomfort when discussing your sensitive story with me, I will refer you to a Clinical psychologist for further counseling. Her name is Prof. Angela Ofori-Atta at University of Ghana Medical School and she has agreed to help out. Her contact number is 020 201 5050.

What are the potential benefits to you and/or to society?

Your participation in this research will not benefit you or your family personally. It will not give you right to any special treatment. It does not mean that you receive any special medication or service. It does not guarantee that your present living (accommodation) circumstance will change. Your participation may well reap benefits for other MHCUs in the future by improving the way we care for them. If during the interview we find out you may need or benefit from other medical or social services you will be referred to the appropriate office such as Social welfare.

Payment For Participation

You will not be paid to take part in the study but you will be served some snack and lunch after the interview. You will also be given a University of Ghana embossed pen. There will be no costs involved for you, if you do take part.

Confidentiality

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of using special codes to identify your tape-recorded chat. *You have the right to listen to* review/edit the tapes. All your information will be stored safely and kept in confidence between the members of the research team. Your audios will be kept on a computer with a password lock on it. Your personal information will be completely confidential and the consent forms that you have signed will be locked away in secured cabinet in an office at the Department of Psychiatry of the Korle bu Teaching Hospital the study.

Researchers at the Stellenbosch University in South Africa will examine information from the study. If the study is published in a journal, all your information will remain confidential. The people who are paying for this research, the study monitors and the Human Research Ethics Committee (HREC) members may also need to look at all the study records but nobody will be able to identify you personally.

Dissemination

After analyzing the information, findings of this study will be shared with the communities participating in the study, the Department of Psychology at the Stellenbosch University, South Africa, Ghana Health Service Ethics Committee and other stakeholders.

Identification of investigators

If you have any questions or concerns about the research, please feel free to contact Beatrice Dwumfour Williams *(Principal Investigator), on 00233099916 and Sarah Skeen (Supervisor)* on *0027727533115* and skeen@sun.ac.za.

You can also contact Prof. Angela (020 2015050) she the local supervisor and providing support to the study. (angela.oforiatta@gmail.com).

Your can also contact the Administrator of the Ghana Health Service Ethics Committee Hannah Frimpong on 050 704 1223.

Rights of research subjects

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

Informed Consent

Statement of Consent:

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and questions I have asked have been answered to my satisfaction. I consent voluntarily to participate in this study and understand that I have the right to withdraw from the study at any time or decline to answer any questions without it affecting my further medical care. I will be given a copy of this consent form.

Name of participant …….

Signature/thumbprint of participant …….. Date ……

If parent/guardian are not literate, an impartial witness must sign to indicate that he/she was present when the consent explanation was given.

Witness' name …… Signature …… Date ……

I confirm that I have done the consent process to applicable regulations

Name of investigating Team Member:……. Signature ……..

Appendix D: Semi-Structured Interview for Mental Health Consumers at the Accra Psychiatric Hospital

Interviewer's Instructions to Participant: "I will like to start by first thanking you for agreeing to participate in this interview. As you already know I am going to ask you a few questions during the next hour to hour and a half (60 – 90 minutes). These questions are going to be about your experiences of MHCUs once the leave the psychiatric hospital I am hoping that the information that you provide or share with me during this interview will help bring to light what the experiences of other mental health consumers (patients) in similar situations are. Please I urge you freely respond as honestly and willfully as possible. You can ask questions if you do not understand what I am asking or ask me to repeat if you did not hear me clearly. Please give as much information as possible because your answers will help provide a good opportunity for understanding your experiences after being discharged. Please be reminded that your participation is purely voluntary. You may decide to withdraw from or discontinue participation in the study at any time without any consequences. Again, you are assured that the information you shall provide will be held in strict confidence. The audio recordings will be kept anonymous and in a secured place. Your name will not be used in all the study data.

After some general demographic questions such as your age, marital status, gender and so forth, I will ask quite a number of specific questions. You can decide not to respond any questions, for any reason. However, I hoping that you will not decline to answer any of them. Nonetheless with your permission, I would like to be able to probe why you declined to answer. When I am through with the questions you may discuss anything that you feel is important but I did not ask you. Please understand that this interview will be audio recorded, as agreed by you, in order for

me write it out at a later date to help me understand and interpret all the information you have shared. Do you have any questions that I can answer for you? If you do not have any questions shall we begin?

Interview Guide by interviewer (homelessness after discharge from Accra Psychiatric Hospital, (n= 15)

	QUESTION	Notes/Key words
	A. I would like to ask you some general background questions (History and insight into mental illness (n=15) Based on your own knowledge and understanding	
2.	What is your past or current psychiatric diagnosis or mental illness	
3.	How long have you had this disorder?	
4.	How did you come to this hospital?	
5.	How times have you reported at this hospital for treatment?	
6.	What were your expectations of the treatment and care?	
7.	What services are you currently being provided with?	
8.	What other services would you like to be provided while here?	
9.	What were experiences after you were discharged?	

	QUESTION	Notes/Key words
10.	What were your expectations after you were discharge	
11.	What happened with previous discharges?	
	B. Now I would like to ask you some questions challenges you have experience with reintegration. What you experience after you went home upon discharge	
12.	How did you react when you were discharged?	
13.	Where did you go (Did you go home?)	
14.	How did your family react?	
15.	How did other people react towards you?	
16.	In what ways did your lifestyle differ from what it was before you were admitted?	
17.	What challenges did you experience with family, friends, work and neighborhood	
18.	What physical health challenges did you experience?	
19.	What challenges did you experience with access to mental health services	
20.	Which other forms care did you seek (prayer camp, spiritualist, herbalist)? Why did you?	

	QUESTION	Notes/Key words
	C. Now I would like to ask you about how you have been living here or elsewhere since you were discharged (Experiences and cause of homelessness)	
21.	How long has it been since you were discharged?	
22.	Where are you staying now? [If still in this facility] Why are you still in this facility?	
23.	What would happen to you if the hospital were to close down and all patients are asked to go back to where they came from?	
24.	Do you think of yourself as homeless [Why/Why not]	
25.	What do you think has led or contributed to you remaining in this facility	
26.	What conditions do you think could have prevented you from being in this situation?	
27.	What are the challenges of living on the hospital grounds even though you have been discharged?	
28.	Which of these challenges do you find most unbearable?	

	QUESTION	Notes/Key words
29.	What dangers do you experience from being homeless within this facility?	
30.	In what ways have remaining in this facility affected your mental health condition?	
31.	What has helped you in coping with your present accommodation situation? (Contributions of family, friends, work, community, society, government)	
	D. Finally I would like to ask you for some general comments about your present status	
32.	***What other comments you would like to make about your current mental health conditions and services received?***	
33.	If you had your way (position of change, authority) what would you do change your present situation (reducing homelessness, community approach to care). ➢ What you mentioned earlier	

	QUESTION	Notes/Key words
34.	Do you have any information that we might find useful for this research?	
35.	Can you suggest other individuals who we need to be interviewed?	
	Would you like to know about the findings or results of this study?	
	What would you like to know about the findings or results	
	Who else would you like to know about the findings or results of this study?	
	How do you want the findings to be made available to you?	
	How do you the findings to be made available to other people whom you think should know?	
	Are there any questions that I have not asked?	

1. Thank you very much for your time. Please be assured this information will be treated confidentially. A written report on the research will be provided once it is completed.