

A Qualitative Study of The Psychosocial, Physical and Spiritual Benefits and Challenges Experienced by Psychiatric Patients Engaging Community Mental Health Services

Ivy Peregrino Brimah¹, Daniel Ofori Mankata², Mustapha Karikari³,
Emma Sename Baxey⁴, Anna Kaye Barrett Thomas⁵,
Ebenezer Asamoah⁶, Lawrence Asamoah⁷, Victor Adeleke⁸,
Akunna Jane Okafor⁹

¹Goaso Nursing and Midwifery Training College, Ghana

²Tepa Nursing and Midwifery Training College, Ghana

³Ulster University, Londonderry- Northern Ireland

⁴NHS SLAM FOUNDATION TRUST, Kent- United Kingdom

^{5,6,7}Cygnnet Healthcare, Bury-United Kingdom

^{8,9}Phoenix Care Centre, Dublin- Ireland

ABSTRACT

Background: Mental illness generates feelings of shame, low self-esteem, isolation, and hopelessness which affect wellbeing and quality of life. Mental health care practitioners, therefore, need to support their clients to improve their quality of life. Despite an increasing awareness of the importance of spirituality in mental health contexts, a religiosity gap exists in the difference in the value placed on spirituality and religion. This may be due to a lack of understanding about the complex ways people connect with spirituality within contemporary society and mental health contexts and can result in people's spiritual needs being neglected or dismissed within clinical practice (K. Milner et al., 2020).

Additionally, mental illness may cause a variety of psychosocial problems such as decreased quality of life of the patient and their family members as well as increased social distance for the patient and the family caring for the patient. Psychosocial challenges are enhanced by the stigma attached to mental illness, which is a problem affecting not only the patient but also the family. Coping mechanisms for dealing with mentally ill patients differ from one family to another for a variety of reasons (Kakuma R et al., 2010).

Objective: The aim of this study was to explore the contribution of community mental healthcare services to the wellbeing of persons with a history of mental illness using the Betty Ferrell's Quality of Life (QoL) model.

Methods: A qualitative research approach was adopted, using exploratory descriptive design to describe the experiences of psychiatric patients engaging community mental health services. An in-depth interview was conducted using Betty Ferrell's Model as a guiding framework. Each interview lasted about an hour. All interviews were audiotaped, transcribed, and the content analyzed thematically. A purposive sampling

method was used to select 11 participants who participated in a face-to-face in-depth interview. Responses from the interviews were transcribed verbatim and analysed using the thematic content analysis approach.

Results: The findings from the study revealed the important and valuable contribution of community mental health nursing services to the quality of life and wellbeing of persons with mental illness in all spheres of their functioning. The main themes and sub-themes on how community mental healthcare services impact the wellbeing of persons with history of mental illness were *Spiritual wellbeing* ('hope', 'transcendence', 'positive changes'), *Social wellbeing* ('good social interaction', 'good relationship with family', 'good relationship with community members', 'good relationship with church members'), *Psychological wellbeing* ('perception of overall quality of life', 'anxiety/depression', 'cognition/attention', 'assertiveness'), and *Physical wellbeing* ('adherence to medication regimen', 'overall physical health', 'functional ability', 'appetite'). Community mental health nurses have also been instrumental in promoting the social wellbeing of people with history of mental illness. Improvement in the spiritual lives and religious activities of the clients through the intervention of the nurses helped them to find some purpose and meaning in life. Counselling, reassurance, encouragement, and education of clients by the nurses provided some relief from their anxieties and depression and promoted client compliance with prescribed treatment regimen.

Conclusion: Both theoretical and empirical literature reviewed show that social and emotional support for persons living with mental illness, or with a history of mental illness, are important to their quality of life. The support given within the community is invaluable. Thus, community mental health care services span the well-being in the domains of physical, social, spiritual, and psychological functioning.

Keywords: Community Mental Healthcare, Quality of Life, Mental Illness, Positive coping skills, Stigmatisation, Psychosocial wellbeing, Betty Ferrell's Model

INTRODUCTION

Background

Psychiatric disorders are the most common cause of disability (Svavarsdottir, Lindqvist & Juliusdattir, 2014). Stigma associated with mental illness produces negative feelings of lowered self-esteem and shame as well as feelings of hopelessness and isolation. People with history of mental illness may have more difficulty with stigmatizing behaviors and attitudes towards them. People deny them their right to work, to have meaningful relationships, proper housing, good healthcare, and all other physical, psychological, and social needs in life. Consequently, their wellbeing gets affected, which is a key determinant of the failure of success of health care systems (Corrigan, Roe & Tsang, 2011).

Persons with mental illness, current or past, need support and care. Recovery from mental illness is a process and individual experiences may differ. It unfolds within a social and interpersonal context (Svavarsdottir *et al.*, 2014) which consists of social networks and relationships as well as the larger society within which one lives. The larger social context must have the requisite resources such as good mental health care support services for the mentally ill. Turton *et al.* (2011) posited that recovery from mental illness is not an indication that all the symptoms of mental illness are gone. However, reflects the improvement of wellbeing and the restoration of one's role as a member of the community. Care and support facilitate the recovery process.

Community mental health care services have been expanded to cover all regions in Ghana and is targeted for improving quality of life and wellbeing of persons with history of mental illness in the community and

the public (Eaton & Ohene, 2016). The spread of community mental health care in Ghana was rejuvenated after the enactment of a progressive Mental Health Act (846 of 2012) (Adu-Gyamfi, 2017). This law initiated a paradigm shift in the approach to mental health care in Ghana from institutional based care to community-based care. Since then, many mental health professionals have been trained and posted to various parts of the country as part of the primary health care system to provide care for the mentally ill in the community (Adu-Gyamfi, 2017).

Literature Review

Introduction

This chapter presents the theoretical framework and relevant reviewed literature on quality of life. The Ferrell *et al.* (1995)'s model of quality of life will be used as a guiding framework for the study. The literature review is presented with a focus on the influence of mental health services on the wellbeing of persons living with mental illness. Sources for information for the review included books, dissertations, and online databases, Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, Psychology Information (PsycINFO), SCOPUS, and Science Direct. Other databases used for the review were the Google database and Google Scholar, both of which offer scholarly literature. The search words used were: “quality of life”, “persons with history of mental illness”, “mental health”, “persons living with mental illness”, “mental health care services”, “psychological well-being”, “physical well-being”, “social well-being”, “spiritual well-being”, “community mental health services” and “influence”. The literature review is organized under the following sub-themes; theoretical model; quality of life theory; quality of life; influence of community mental health care services on the physical wellbeing of persons with history of mental illness; influence of community mental health care services on the psychological wellbeing of persons with history of mental illness; and influence of community mental health care services on the social wellbeing of persons with history of mental illness.

Theoretical background of the study

Theoretical models of quality of life are classified based on the features of the models. This nomenclature has brought about nine broad categories of theoretical models of quality of life. They consist of objective concepts; subjective indicators; satisfaction of human needs; psychological models; health and functioning models; social models; social cohesion and social capital models; environmental models; and ideographic models. Each of these models measures a certain aspect of quality of life. Several scholars have raised concerns about the numerous classification of quality of life theories (Bassah *et al.*, 2018; Bernardino *et al.*, 2012; Karimi & Brazier, 2016). Generally, there is agreement in the academic world that some of these classifications are redundant since some are essentially a derivative of other existing theories.

Amidst all the confusion and debate on theoretical models of quality of life, Ferrell *et al.*, (1995), bring some finality to the debates by combining essential features of the many categories of the theories that exists into one theory. They summarize quality of life into four main domains: namely, physical well-being, social well-being, psychological well-being, and spiritual well-being. This study uses the quality of life model by Ferrell *and colleagues* (1995) because it is comprehensive and creates room for exploring quality of life from varied perspectives, unlike the other theories that are limited in scope.

Each domain of the model focuses on an aspect of wellbeing. Physical well-being is the capacity of the individual to maintain a functional ability and possess the bodily power to perform activities of daily living effectively. The individual must be able to rest, sleep, and eat adequately. One other characteristic feature

of physical well-being is the absence of any disease or infirmity. Common signs and symptoms of illness such as aches/pain, constipation, nausea, and fatigue are crucial in assessing the physical well-being of an individual.

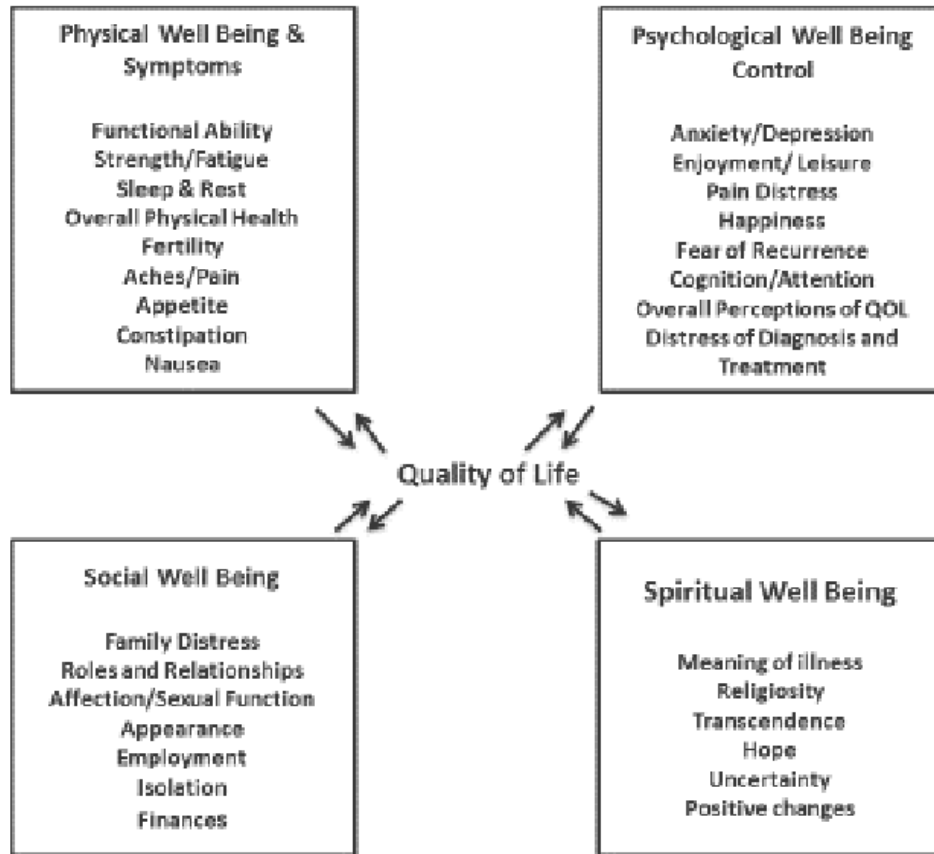


Figure 1. Ferrell et al. (1995)’s framework on quality of life

Psychological well-being refers to the state of being whereby the individual is self-efficacious, confident of own abilities, has the ability to solve daily problems encountered and is able to make meaningful contributions towards society. Aspects of psychological well-being, according to the model include control, anxiety, depression, employment/leisure, pain distress, happiness, fear of recurrence, cognition/attention, overall perception of quality of life, and distress of diagnosis and treatment. People who are considered as being in the state of psychological well-being are in control of their sickness and do not disproportionately get anxious about their illness. Some level of anxiety about the occurrence of negative experience is normal for a human being. However, when the anxiety is exceedingly debilitating and interferes with the ability of the individual to function effectively, then there is probable cause to suspect psychological well-being imbalance. In addition, there are occasions during which psychological ailment may manifest as a physical condition. This is broadly known as somatic symptoms, but according to the Ferrell et al., (1995) model, it is referred to as pain distress. Ability to remain focused on a task or during social activities like communication reflects the cognition/attention aspect of psychological well-being.

Quality of life issues relating to social well-being are basically relational and “include family issues, such as sexual and marital problems and adjustment of children; and work-related issues, stigma, reentry into

the workplace, changes in work priorities, discrimination” (Ferrell *et al.*, 1995, p.523). Social well-being is also concerned with management of roles in relationships, appearance (social status) and employment. Spiritual well-being is the capacity to preserve hope and meaning from adverse experiences, such as conditions of ill health, which is often characterized by uncertainty and despair. Other sub-themes of the spiritual aspect in the Ferrell *et al.*, (1995) model are meaning of illness, religiosity, transcendence, hope, uncertainty, and positive changes.

Quality of life

According to Karimi and Brazier (2016), the term, quality of life (QoL) has been in use in the health field since the 1960s. The emergence of quality of life was due to advancements in health that made it clear that health was not only able to extend the duration of one’s life but also to improve upon the qualitative aspect of an individual’s well-being. For instance, people did were not only cured of diseases, but also, they were taught by health care workers to put measures in place that improved their physical, mental and social well-being (Dawson, 2018; Karimi & Brazier, 2016). Some of these measures such as personal hygiene, good diet and routine exercises, maintaining healthy social relationships and others (Dawson, 2018).

Quality of life (QoL) is a multi-stage and unstructured concept and is general as an endpoint in the assessment of public policy (for example results of health and social care). Whereas the core fields of quality of life acknowledged in the literature are applicable to all and sundry, these can differ in priority among people in varying age groups. Due to this variation, there is not a generally acceptable and conclusive theoretical framework of quality of life, and studies that have sought to investigate quality of life have resorted to different frameworks in doing so (Janodia, 2016). Therefore, even though there is an abundance of academic pieces on several objective and subjective indicators of QoL, there exists no commonly recognized or agreed model or measurement instrument of quality of life (Janodia, 2016; Karimi & Brazier, 2016).

The variations in the conceptualization of quality of life and its measurement have affected the definition of quality of life as well. The macro definition of QoL refers to using structured elements such as income, housing, standard of living, educational level, employment and other factors relating to the environment to qualify quality of life (Litwin, 2010). For this reason, the macro definition of quality of life is subjective in nature. To the contrary, the micro definition seeks to cast quality of life in a subjective light (Lavdaniti & Tsitsis, 2015). This implies an individual’s perceptions of his or her general quality of life, personal experiences and standards, and pleasure and fulfillment (Lavdaniti & Tsitsis, 2015).

In recent times, a new school of thought has emerged on quality of life. This category of academics is of the view that a distinction should be made between quality of life in general and the specific aspect of quality of life that pertains to health. But just like quality of life, there is no generally accepted definition of health-related quality of life. Health-related quality of life can be defined as “how well a person functions in their life and his or her perceived wellbeing in physical, mental, and social domains of health” (Dawson, 2018; Karimi & Brazier, 2016, p.34). Considering the striking similarities between quality of life and health-related quality of life, researchers have generally settled on using quality of life to mean health-related quality of life, even though some disagreements persist (Dawson, 2018; Karimi & Brazier, 2016; Madani *et al.*, 2018)

The influence of community mental health care services on the physical wellbeing of persons with history of mental illness

Mental health services such as symptom management provided the opportunity to persons with history of mental illness to have good sleep, and good nutrition. In addition, people living with mental health had reduced instances of physical pains such as headache and stomach pains. Cognitive behavioral therapy enhanced self-management skills and reinforced interdependence and independence rather than dependence of persons living with mental illness in London (Slade, 2010).

The influence of community mental health care services on the psychological wellbeing of persons with history of mental illness

Hanrahan *et al.*, (2011) carried out a quasi-experimental study among some 238 persons with history of mental illness in Pennsylvania to determine the impact of mental health care services on their quality of life. Findings of the study showed that depression was significantly reduced among the patients in the first three months of their receiving mental health care. A further reduction was seen as the duration of mental health care rendered to the patients increased to six months and then twelve months. Again, a pre-test/post-test study aimed at understanding the impact of mental health care hospitalization on the level of depression among some 142 persons with history of mental illness in Ontario, Canada indicated that the mental health outcome of the participants improved after 6 months of institutionalization (Markle-reid *et al.*, 2014). Participants who were severely depressed either improved to a moderately depressed state or no depressed state whilst depression was entirely absent on those who were moderately depressed at the beginning of the study (Markle-reid *et al.*, 2014).

In India, school mental health services were associated with an improvement in the psychological wellbeing of students (Sidana, 2018). Students with conduct disorders and intellectual disability were able to improve due to personalized mental health care that was rendered to them as part of the school health program (Sidana, 2018).

The influence of community mental health care services on the social wellbeing of persons with history of mental illness

Persons living with mental illness in Australia confessed that the mental health care service given to them enhanced their independence and facilitate social connectedness (Heslop *et al.*, 2016). Mental health care services help persons with history of mental illness to return to their communities as well as proving stable or improved level of functioning in community. Adu-Gyamfi (2017) established that the lack of opportunity for lawyers in the country to specialize in mental health law denies persons with history of mental illness in Ghana the opportunity to seek redress on legal issues which affects their basic rights.

METHODOLOGY

Introduction

This section provides a description of the methodological processes of this study. This includes the research design, research setting and target population. A description of the sample and sampling technique has also been provided including the tool for data collection, data analysis process and ethical issues.

Research Design

The research design is referred to as the blueprint for carrying out a study which has total control over all factors with the tendency to influence the validity of the findings (Polit & Hungler, 2013). In this exploratory study, a descriptive qualitative design was used as a guide. According to Fain (2013), the qualitative approach to research provides one with the opportunity to acquire deeper understanding and rich descriptions of people's experiences of the phenomenon under study. This helps to provide insights into the problem and thus facilitate in-depth exploration and knowledge on the topic under investigation; consistent with the main goal of qualitative research which is to gain insight of the richness and complexity that characterize the phenomenon under study.

The explorative approach to qualitative research involves investigating the full nature of phenomena rather than simply observing and explaining the phenomena and this provides an insight into comprehension of an issue or situation (Polit & Hungler, 2013). The flexibility of data sources such as the use of secondary data, interviews, and discussions, in addition to its focus on understanding a phenomenon rather than making definite conclusions are some of the advantages of exploratory approach to qualitative research. An exploratory descriptive research design helps the researcher to have an objective and accurate description of the phenomenon under study (Polit & Hungler, 2013). The exploratory descriptive qualitative design helped the researcher to explore and describe the effect that community mental health care services have on the wellbeing of persons with history of mental illness in the Asunafo North Municipality.

Target population

The population for the study comprises persons with history of mental illness and living in the Asunafo North Municipality.

Inclusion and Exclusion Criteria

Patients with history of mental illness who were considered to have improved in their mental state in the Asunafo North Municipality qualified for inclusion into the study. These were persons 18 years of age and above, who receive health care services from the community mental health professionals in the Asunafo North Municipality. These were not actively psychotic persons but recovering patients. Patients who were acutely disturbed or physically ill were excluded from the study.

Sampling/ Sampling Method

The purposive sampling technique was used to select participants for the study. This is a form of non-probability sampling technique whereby subjects or participants are selected based on certain properties that are of interest to the researcher. This sampling technique enables the researcher to select the participants based on their knowledge of the phenomenon under study and for the purpose of sharing that knowledge with the researcher (Polit & Hungler, 2013).

In this study, only matured persons with history of mental illness in the Asunafo North Municipality, 18 years and above, who receive health care services from the community mental health professionals were purposively identified and recruited for the study. This was done with the assistance of the community mental health staff in the Asunafo North Municipality. These staff served as contact persons who helped the researcher to identify persons with mental illness and to whom they provide services who qualified for inclusion into the study. These were introduced to the researcher. The researcher, after informing them

about the study, obtained their informed consent. Those who agreed to participate were recruited for the study. There was no coercion of any sort. Those who participated did so voluntarily.

Calculation of Sample Size

Khan (2012) describes sample size as the total number of subjects in a study. In qualitative research the number of participants cannot be determined a priori because it is an inherently problematic approach (Sim, Saunders, Waterfield & Kingstone, 2018). An estimated 10 to 15 persons with history of mental illness were targeted to be selected for the study. However, data saturation (Walker, 2012) was reached at the 11th participant. This was when successive participants provided similar responses and no new ideas, themes or sub-themes were then generated.

Data Collection and Analysis

Data collection tool

Data was collected through face-to-face in-depth interviews using a semi-structured interview guide. This is a tool in which open-ended and direct questions are used to elicit detailed narratives and stories (Polit & Hungler, 2013). It is very flexible and provides the interviewees the opportunity to freely express themselves and provide in-depth information concerning their experiences of the phenomenon under study. Furthermore, it allows the researcher the opportunity to seek clarifications through follow up questions (Kusi, 2012).

The interview guide was in two sections. The first section covered demographic characteristics of respondents. These include their age, sex, religious affiliation, marital status, highest educational level. The second section comprised open-ended questions on the influence of community mental health care on the well-being of persons with history of mental illness. These covered aspects of their physical, social, psychological, and spiritual well-being. This was designed based on Ferrell *et al.* (1999)'s quality of life model and reviewed literature.

Data collection procedure

Formal permission was sought from the Asunafo North Municipal Health Director and the heads of the community mental health units in the municipality before the data collection process. Informed consent was obtained from the selected participants and individual face-to-face interviews were scheduled according to the convenience of the participants.

With the help of the community mental health staff, patients who were selected and agreed to take part in the study were asked to sign a consent form as an indication of their consent to participate in the study. The interviews begun with questions on the socio-demographic characteristics of the participants to establish rapport with them before going on with questions pertaining to the main purpose of the study. The interviews were then continued with open ended questions on the subjected matter under study and the participants were allowed to speak uninterruptedly on the subject matter. Subsequent probing questions were also asked for further exploration of emerging themes. This was done after the researcher listened attentively and noted down issues which needed to be revisited for clarification.

Interview sessions lasted between 30 to 60 minutes. Interviews were conducted in English or 'Twi' (a common vernacular in Ghana) as a respondent preferred. A digital audio recorder was used to record each interview and field notes were also taken from observations made during each of the interviews. A total

of 11 persons with history of mental illness were interviewed for the study. These interviews were carried out in October 2020. The interviews ended with the 11th participant after data saturation was achieved.

Data analysis

According to Polit and Hungler (2013), data analysis is an integral part of the research design, and it is a means of making sense of data and presenting them in an understandable manner. Data analysis was done using thematic content analysis approach. Interviews were transcribed verbatim, and transcriptions were read several times to obtain full understanding of participants' accounts. The principles of thematic content analysis were employed to develop sub-themes and themes that emerge from the data in line with the quality-of-life model. The thematic content analysis was done using the MAXQDA Plus 2020 software for qualitative data analysis. Field notes taken during the interviews were analysed and added to the data to provide additional explanation and clarity to the findings of the study. Verbatim accounts of respondents have been used to support the themes and sub-themes emerging from the data. Codes were used, instead of the respondents' real names, to conceal their identity. Interpretations from the data were reviewed to ensure that themes were fully developed. In the report of the findings, the themes and sub themes were presented and supported by verbatim quotes from the participants in accordance with thematic analysis exemplars (Korsah, 2015).

Ethical consideration

Formal permission was sought from the district community mental health nursing coordinator in the form of a letter seeking permission to collect data for the study. Permission was also sought from the participants. The participants were informed about the study and their consent was sought before the interviews were carried out with them. They were asked to sign a written consent as evidence of their willingness to participate in the study. To ensure privacy, the interviews were carried out privately without any interruption from others. Names of participants were not recorded. Participant responses were rather identified with codes in the report to ensure anonymity. All filled transcripts and audio recordings were kept safely away from the public and made only accessible to the co-researcher to ensure confidentiality.

RESULTS

Introduction

This chapter presents the findings from the exploratory descriptive qualitative study. This comprises findings on how community mental healthcare services influence the wellbeing of people history of mental illness using Betty Ferrell's quality of life model. These findings were based on in-depth face-to-face interviews carried out with people with history of mental illness within the Asunafo North Municipality.

Demographic Characteristics of Respondents

The demographic data of the participants that were taken included age, sex, employment status, highest education level, marital status, religion, ethnicity, diagnosis, and duration of mental illness. Among the 11 participants, 7 were females while 4 were males. The youngest one was 21 years old followed by 2 who were 27 and 28 years old respectively. Two were 30 years old and 4 were 33 years old. The remaining 2 were 49 and 52 years old, respectively. Five were traders and 1 was a farmer. The remaining 4 were unemployed. Among the younger ones, 2 had junior high school education and 7 had senior high school education. The 2 elderly ones had O' Level and A' Level education. Five were single and 5 were married.

One however, was divorced. They were all Christians. Nine of the were Akans and 2 were Ewe’s. Three had history of schizophrenia, two each had history of substance induced psychosis, hypomania, and depression, respectively, and one had history of bipolar disorder. Two each had lived with the condition for 2 years, 5 years, and 6 years, respectively. Three had lived with the condition for 3 years and the remaining two had lived with the condition for 18 and 24 years, respectively (Table 1).

Table 1: Demographic characteristics of participants

Nº	Code	Age	Sex	Employment status	Highest education level	Marital status	Religion	Ethnicity	Diagnosis	Duration of mental illness
1.	1F	49	Female	Trader	A' Level	Divorced	Christian	Akan	Schizophrenia	18
2.	2F	33	Female	Trader	Senior High School	Married	Christian	Akan	Schizophrenia	2
3.	3F	52	Female	Trader	O' Level	Married	Christian	Akan	Mania	24
4.	4M	33	Male	Farming	Senior High School	Married	Christian	Akan	Depression	5
5.	5F	28	Female	Trader	Senior High School	Single	Christian	Akan	Bipolar Disorder	3
6.	6M	21	Male	Unemployed	Senior High School	Single	Christian	Ewe	Substance Induced Psychosis	6
7.	7F	30	Female	Unemployed	Junior High School	Single	Christian	Akan	Hypomania	5
8.	8F	33	Female	Trader	Secondary	Married	Christian	Akan	Schizophrenia	2
9.	9M	33	Male	Teacher	Senior High School	Single	Christian	Akan	Depression	3
10.	10M	27	Male	Unemployed	Senior High School	Married	Christian	Akan	Substance Induced Psychosis	3
11.	11F	30	Female	Unemployed	Junior High School	Single	Christian	Ewe	Hypomania	6

Themes and sub-themes

From the thematic and content analysis that were carried out on the data, four themes and fifteen sub themes emerged. The 4 main themes and 9 sub themes were from the main constructs of Ferrell *et al.* (1995)’s framework on quality of life that was employed to guide the study. The remaining 6 sub themes emerged from content analysis of the data.

The main themes and sub themes on how community mental healthcare services influence the wellbeing of persons with history of mental illness were Spiritual wellbeing (‘Hope’, ‘Transcendence’, ‘Positive changes’), Social wellbeing (‘Good social interaction’, ‘Good relationship with family’, ‘Good relationship with community members’, ‘Good relationship with church members’), Psychological wellbeing (‘Perception of overall quality of life’, ‘Anxiety/ Depression’, ‘Cognition/ attention’, ‘Assertiveness’), and Physical wellbeing (‘Adherence to medication regimen’, ‘Overall physical health’, ‘Functional ability’, ‘Appetite’) (Table 2).

Table 2: Themes and sub-themes

Theme	Sub-themes
Spiritual well being	Hope
	Transcendence
	Positive changes
Social well being	Good social interaction
	Good relationship with family
	Good relationship with community members
	Good relationship with church members
Psychological well being	Perception of overall quality of life
	Anxiety/ Depression
	Cognition/ attention
	Assertiveness
Physical well being	Adherence to medication regimen
	Overall physical health
	Functional ability
	Appetite

Spiritual wellbeing

Spiritual wellbeing represents meanings that participants got about life and their hopes and expectations for a better life. Experiences on drawing closer to God, becoming more spiritual and experiencing some positive changes in ones’ life in terms of becoming more active in church activities were narratives about the spiritual wellbeing of the participants. The sub-themes that emerged from the theme ‘spiritual wellbeing’ were ‘Hope’, ‘Transcendence’ and ‘Positive changes’.

Hope

Hope was expressed in terms of meaning in life and expectations for a better life. Participants eventually came to realization that life experiences were characterised by good and bad times and that one needed

to understand these seasons in life to appreciate how to handle these events as and when they unfold without losing hope. Below were some of the responses by the study participants:

‘Yes, at first, I used to be down. But I have realized that life is not straight. There are ups and downs and you really must know how to handle yourself.’ (5F)

Participants’ interactions with the community mental health nurses gave them the opportunity to come to the realization that life meant more than getting overly concerned about a disease condition. This realisation prompted a change in their perception and understanding about life.

‘Now I see that there is more to life than just this disease. They have changed my life. When I recovered, I have realized that there is more to do in life.’ (4M)

Some participants lost hope because of their mental condition. However, after some visits and interactions with the community mental health nurses, they began to see something positive about themselves. Their hopes were rejuvenated and now, they have good reasons to live and look forward to a better life.

‘I almost lost hope. When the nurses started coming again, their advice has really helped me.’ (5F). ‘Formerly, I had no hope in this life. But now due to the frequent visits from the nurses, I have better hope.’ (7F).

In response to these realisations about the meaning of life and their expectations for a better life moving forward because of their engagement with the community mental health nurses, some participants admitted that one needed to have an aim or a purpose in life as follows: ***‘You see in life; you must have an aim. So, there’s more that I’ll like to do.’ (2F)***

Transcendence

Transcendence refers to the beyond physical experiences of the participants from their engagement with the community mental health nurses. Participants were drawn closer to God due to the spiritual upliftment they had whilst engaging with the community mental health nurses. They reiterated this as follows: ***‘They have helped me to draw close to God.’ (3F).***

Frustrations about their mental illness made some of the participants question why God will allow this to happen to them. Consequently, some had to even stop going to church because they found no reason to do so. However, after receiving some education from the community mental health nurses, their perception about their condition changed. This further changed their attitude towards God positively. Related to this are some comments by the participants: ***‘When I come home too, I read the bible and ponder over what I have heard. This has nourished me spiritually and drawn close to God.’ (3F). ‘When I came home from admission, I was even blaming God, why why why? So, I even stopped going to church. But when they came around everything changed.’ (6M).***

Interactions between participants and the community mental health nurses had a positive effect on them spiritually by drawing them closer to the things of God. Some participants began to pray. One other participant recounted that she got healed when she began to combine prayers with her prescribed medications. This is what the participant had to say: ***‘It has affected me positively. Because even before we start our session, we pray before we start.’ (4M) ‘Yes. Because of my condition, I used not to pray. But one nurse told me to pray. So, I was taking my drugs and praying to God, and this has helped in healing me.’ (5F)***

Positive changes

The main positive change that the participants had in their spiritual life was going to church. Those who stopped going to church resumed church activities after having a change of mind about their condition, themselves and about God. Participants begun going to church frequently and listening to sermons for inspiration. Regarding this, participants mentioned: *'Now I go to church and even sit at the front. I listen to the sermons carefully.'* (3F). **Another participant also stated that: 'Everybody around has realized that they have help improve my condition. And by God's grace the church members to do not neglect me. So, their visit has helped me.'** (11F)

Participants explained that these positive changes in their spiritual lives were because of encouragement from the community mental health nurses. The community mental health nurses encouraged the participants to improve their spiritual wellbeing by going to church, praying, and getting involved in church activities. Below are some comments by participants in this regard: *'They also tell me to go to church.'* (10M); *'They always encourage me to go to church. They are very spiritual. They told me that aside the medication, I must also pray. So, I do just do that.'* (7F); *'Yes, they tell me to go to church. When they come, they tell me that God can also heal.'* (2F); *'Yes yes. I go to church. They told me that aside taking my medications, God can also heal me, so I need to go to church. At times, they ask me what I learnt at the church.'* (1F).

Some participants became very active in church by taking on some roles in church. They joined Bible study groups in church. One also became a deaconess and she also helped in cleaning of the church premises. They had this to say: *'I have even joined the bible study group in order to know God very well.'* (1F); *'I go to the church to help clean and I'm a deaconess too.'* (5F).

Social well-being

Social wellbeing represents the quality of the nature of the relationships that participants have with people around them. These relationships include general social interactions in addition to general relationships with family, community members and church members. Four sub-themes associated with this theme included 'Good social interaction', 'Good relationship with family', 'Good relationship with community members' and 'Good relationship with church members'.

Good social interaction

Participants explained that they can come out to express themselves and be able to interact freely with people because of their engagement with the community mental health nurses. Some used to stay at home and avoided interacting with people. However, their encounter with the community mental health nurses changed the way they interacted with people. Those who were shy and withdrawn were now able to open and socialise with others. They mentioned that: *'They helped me to unbox myself and to come out to express myself well.'* (4M). **Again, 'With my condition I kind of stayed away from people, moved away from people but now I am able to go back to my normal life.'** (11M); *'Earlier I wasn't interacting with people. I used not to smile and shout at people but now I'm able to talk to people well and patiently too.'* (5F).

One participant explained that he used to talk impolitely to people around him due to the influence of his mental illness. However, as his symptoms resolved with the assistance received from the community mental health nurses, he begun to talk well to people around him. He states: *'With people I'm able to talk to people and understand them more without any argument. At first, I talk to them anyhow but now I talk to them well.'* (9M).

Participants recounted a change in the way people related to them in the past. People who used to avoid their company and were uncomfortable getting along with them now drew closer. Friends could now come along and watch television with them – something that seized because of their mental condition. The participants explained these changes were as result of improvement in their mental health status due to the assistance they got from the community mental health nurses. Pursuant to this the participants underscored the following: *‘Formerly people used not to come close to me but now they come close because they have realized that I’m in a good condition. So, their interaction with me has really helped.’* (11F). *‘Now I normally sit at home watching T.V and at times my friends will come around for us to chat and we get along well now.’* (4M); *‘Some of my friends visit me. Some of them too they call me to see how I’m doing.’* (2F); *‘When I came back from the hospital, I liked to sit at one place and not mind anybody. But now I’m able to talk with those around and my friends too.’* (6M). In furtherance, the participants explained that the poor attitude of people towards them was a result of a lack of understanding about mental health and mental illness. One of the participants stated, *‘I believe they didn’t have proper understanding of my condition that’s why.’* (5F).

The health education and community sensitization activities of the community mental health nurses were linked to the change in community perception and attitude towards the participants. These positive changes in community perception and attitude towards some of the participants had been a great relief to them as emphasized by the participants in their response as follows: *‘Aside that they talk to people around to make sure that they cooperate with me.’* (6M); *‘At first, I was moody and was also thinking about how people will see me and react. But now because when the nurses come around, they talked to people surrounding me, they are enlightened and now they love me more.’* (8F); *‘First they used not interact well with me but when the nurses started coming and they spoke to them we are able to interact well.’* (10M). To some participants, the community mental health nurses are very friendly and help them to relate well with others. One study participant mentions: *‘Okay they’re very very friendly. They act as our friends and help us to relate with others.’* (2F).

Others were stigmatised just because they had once been admitted to the psychiatric hospital. However, with the intervention of the community mental health nurses, these behaviours were quelled. Below are some comments by participants in this regard: *‘They used to criticize me because I went to psychiatric hospital but now, they talk to me, when I greet them, they respond, and they come to buy my things too at my shop.’* (1F); *‘Some of them, they didn’t want to talk to me. But now they come to me and ask how I’m doing and they’re also helping me to get well. And my friends too some of them come and visit me, and the people in my area.’* (10M).

Good relationship with family

Due to the intervention of community mental health nurses, participants’ relationship with the members of their families improved. Some family members of the participants practically avoided contact with the participants because of their mental health condition. However, with the intervention of the community mental health nurses, these relatives begun to understand the mental health condition of the participant and changed their attitude towards them by drawing closer to them and interacting with them. Here are some comments by participants in relation to this: *‘Yes. Formerly some of my family members didn’t want to come close to me. But after these nurses came around, now they come close to me because the nurses have changed their mentality towards me.’* (4M); *‘because they spoke to my family about my condition, so my family also understood what I’m going through, and our relationship is better.’* (5F).

Participants that used not to be considered as a part of their family were accepted by their families. The participants now valued because they could now be a part of their family gatherings and activities and their opinions were now being heard. This is what one participant had to say: *'Now I'm part of humans. During funerals and other family gatherings, my decisions are also heard. I follow them. I partake in activities of the family. I interact well with them.'* (3F). Moreover, participants now testified that their relationship with their family members had improved. Relatives now interacted well with them and showed concern about their medications and treatment in general as they emphasized that, *'Now my interaction with the family is very fine.'* (7F); *'Yes, it has improved. They chat with me, ask of my medication. Some didn't want to talk to me at first but now they're able to talk to me well, I understand them, and they also understand me, it has improved.'* (2F).

Good relationship with community members

Participants also recounted that their relationship with community members improved because of the intervention of the community mental health nurses. To most of them, the attitude of community members towards them has improved as mentioned as follows: *'The attitude of community members towards me is improving.'* (4M); *'Yes, the way community members interact with me has improved. Because the nurses have talked to people about my condition.'* (6M).

One woman had to close her shop because community members who were her customers were not patronising her goods. But after some community sensitization by the community mental health nurses and the support of the nurses towards her recovery, she reopened her shop and community members begun to patronize her services. Another, who now sells orange said her business is getting better due to her positive relationship with community members. They had this to say: *'There was a reduction in the number of my customers but now that I have opened up, the customers have started coming.'* (5F); *'Okay I'll say I'm happy with them. They buy my orange too to also promote my business.'* (2F). The interaction of participants with the community mental health nurses also improved upon their own interactions with their community members as well. She states: *'My interaction with the community health nurses has improved how I interact with people.... Also, it has made me accept my condition and I am able to talk free to people around me.'* (6M). Additionally, one participant whose relationship with community members improved due to the intervention of the community mental health nurses is now motivated to make new friends and educate more people on mental health and mental illness. This reflects in the participant's comment as follows: *'The relationship is very good. But now I want to make new friends also make them aware of this situation. When I go to market, I have some of my colleagues who I advise them and advise me and ask of how I'm doing.'* (2F).

Good relationship with church members

Good relationship with church members was described in terms of participants activeness with people in church and in church activities. Others also resumed their roles in church that were disrupted because of their mental condition. Some participants who used to be in women's fellowship went back to join. Others with their experience were now training other church members to take up the role they used to play as ushers in the church. One other participant was now under training in church to be an usher. In this regard, participants mentioned that *'Formerly I was part of women's fellowship, but now I'm restructuring things to re-join the fellowship. Formerly the fellowship used to visit me but now I go with them to visit others. See what God has done for me? So, the services are helping me.'* (3F); *'Now I train others. If*

someone wants to be an usher, I train the person to know what to do as an usher.’ (4M); ‘In church I’m training to be an usher.’ (2F).

Psychological well-being.

General cognition, mood, assertiveness, and overall perception about quality of life represented psychological wellbeing of the participants. These included general insight of the participants into their condition as well as improvement in their memory. Changes in mood including relief of anxiety and depression were reported in addition to improvement in level of confidence. Participants also gave a self-appraisal of the changes and relief of symptoms of their mental illnesses. The sub-themes discussed under this theme are ‘Anxiety or Depression’, ‘Cognition or attention’, ‘Assertiveness’, and ‘Perception of overall quality of life’.

Anxiety or Depression

Participants recounted changes in their mood in terms of improvement in the way they felt compared to earlier feelings they used to have. Participants used to be sad and felt bad about themselves. Others used to be anxious and easily irritable and were not able to control their feelings. However, with treatment and frequent visits from the community mental health nurses, these negative emotions seemed to resolve or had resolved completely. These were some responses from the study participants in this regard: *‘Formerly, I used to feel sad but now that feeling is lost.’ (4M); ‘First, I used to feel down, very sad or get anxious and angry easily. But now I am better. I have even realized it that I am able to control my emotions and it has helped me a lot.’ (2F); ‘I think I was depressed earlier. But after the nurses encouraged and spoke to me, I began to feel better’ (5F). Additionally, most of them concluded that they feel good and happy now as stated below: ‘I am quite happy now.’ (4M); ‘I think I am happy now. The nurses have helped me to feel good now.’ (5F).*

Cognition or attention

Changes in cognition and attention were also reported among participants. These were concerning improvement in insight and improvement in memory in which improvement in ability to recall events was cited as evidence of memory improvement. These were because of education and counselling received from the community mental health nurses in addition to their encouragement and supervision of participants medication regimen during home visits. Education of participants on the causes of their mental illness made them to gain more insight into their condition. Participants now got to understand that the cause of their mental illness was not their fault and the need for them to continue with treatment. This helped and motivated them to continue with treatment as prescribed. For instance, study participants mentioned that *‘Yes. I think I know a lot about my condition now. Yes, they made me understand that life is not easy. So, the nurses made me to understand my condition.’ (5F); ‘And I was thinking too much. So now I have understood it and able to solve family issues well and better.’ (10M); ‘They told me that my condition is not my fault. It’s hereditary and that if I follow their advice, it will be managed, and I’ll be able to get better.’ (2F); ‘The nurses made me to understand that my illness is from my family, so it is not my fault. So, they have made me understand it like that. So, I am also coping with them.’ (1F).*

Some participants who were anxious about the cause of their condition became relaxed and calmed down after the nurses made them to understand that it was hereditary. This helped them to come to terms with

their condition, accept it and to get along with their treatment. Here are some opinions given by the participants regarding this: *'When the nurses visited, they told me my condition is hereditary. So now I don't think too much about it. I have accepted it and I feel relaxed now. (9M); 'Yes, it is hereditary. So, I understand there is nothing I can do. All I must do is to take my medication. So, I have accepted.'* (3F); *'As I said earlier, they help me to always take my drugs and help me accept the fact that I have the condition.'* (6M); *'Yes, I have accepted it and they have also helped me to help me manage it.'* (1F). Aside from gaining insight into their condition and subsequently accepting their condition, some participants mentioned that they also noticed changes in their memory. Some participants explained that they used not to remember at first but now they have noticed some improvement in their memory. This is captured in their responses as *'With my memory, at first, I used not to remember some things. But now it is getting better.'* (1F). Furthermore, other participants gave account of complete improvement in their memory. They could now remember everything about themselves, and the symptoms of forgetfulness were now all gone. For instance, some study participants states, *'It was at first that I used to forget, but now I remember everything. At first when I place something down, people will come for it because I forget about it.'* (3F); *'Before then, I easily forget, but now I always remember.'* (4M); *'Yes, I am able to remember everything well now.'* (7F).

Assertiveness

Frequent visits and interactions with the community mental health nurses also increased confidence among the participants. Participants become more confident, assertive and could now interact with people and express themselves better. Through their interaction with the nurses, the participants were able to master the courage to confront persons who tried to take advantage of them because of their mental condition. They could now express and assert themselves as captured in their responses as follows: *'But now I'm able to confront anyone who picks my thing and retrieve them back. I can remember well now.'* (3F); *'The nurses have changed my mentality about mental health. At first, I did not have the courage to talk to people because I felt I will get victimized. But due to their guidance and counselling, now I'm able to express myself.'* (4M). Again, participants now had the confidence, were now able to assert themselves and even go on ahead to educate others among mental health and mental illness. They now had a generally positive perception about themselves and could now brave it to talk to people about themselves and their condition with no fear of being victimised or stigmatized: *'Okay. I am now able to do those things I could not do ever since I met the nurses. At first, I was afraid that people will criticize me when I go out but through their counselling, I am confident and able to go out and talk to others about my illness and also how to manage it.'* (1F); *'Now I feel very positive about myself. I am not ashamed to go outside or to tell others about my story.'* (2F).

Perception of overall quality of life

Participants had a change in their overall perception about their quality of life. This was concerning their perception about relief from the signs and symptoms of mental illness they used to experience. Those who used to feel bad about themselves now felt good about themselves. This was linked to the support in terms of medication and counselling services they received from the community mental health nurses. Various participants shared their opinions as follows: *'My condition has improved.... Because at first during my illness, I used not to talk and was very dull, but now I feel okay. ... I feel I'm normal now'* (4M); *'At first when I wake up, I used to feel not always good in my system. I used to feel some way. But with*

their medication and their counselling, when I wake up, I am happy and fine with my environment and the people around me.' (1F); **One participant described her general wellbeing as experiencing a positive effect in the way she feels about herself. She states, 'Okay there has been a positive effect in the way I feel. I feel I doing so well now.'** (5F).

Physical wellbeing.

Participants descriptions of their physical health in addition to activities carried out to ensure general physical health represented their physical wellbeing. These included their compliance with prescribed medication regimen, account of their general ability to carry out activities of daily living, nutrition, and overall physical health. The sub-themes under this theme are 'Adherence to medication regimen', 'Functional ability', 'Appetite' and 'Overall physical health'.

Adherence to medication regimen

One facet of physical wellbeing mentioned by the participants was their ability to adhere to prescribed medication regimen. According to the participants, the nurses paid attention to their medication regimen. They were educated and counselled on the need to take their medications and the importance of their medication to them. The respondents had this to say in this sense: *'The nurses also talk to me about my medications and the importance of it.'* (4M); *'They help us take our medicine, ask us about our daily lives and help us improve on it.'* (2F). Most of them had a lot of support and encouragement from the community mental health nurses to take their medications judiciously and according to prescription. The nurses also supervised the participants to take their medications at home. They stressed the following in their responses: *'As I said earlier, they help me to always take my drugs ...'* (6M); *'When I returned from the hospital, the nurses came around. For the medications, they encouraged me to take it on time. So, I always make them aware that I'm taking the medications judiciously.'* (3F); *'The nurses help me take my drugs. They always make sure that I have taken my drugs.'* (7F); *'and the nurses helped me to take my medicine and whenever I need help, I am able to call them, and they listen to me.'* (1F). Participants who used not to take their medications were now taking their medications according to prescribed regimen because of persuasion from the community mental health nurses. In this regard, they mentioned the following: *'I wasn't really taking my drugs and when I got discharged from the hospital. The nurses then came to check on me to see that I take my medication on time and all that ... Now I know that things will get better and as I am now taking my drugs.'* (5F); *'At first I used not to take my drugs. But now I do take all my drugs because of the nurses.'* (7F); *'Yes. I didn't like taking medicine at first. But they told me that it will make me get better and prevent any further sicknesses or illnesses.'* (2F); *'Now I take my medicine regularly. At first, I didn't like taking it at all but they have helped me to take my medicine and they have explained to me that it will help me so I take it.'* (10M).

Functional ability

Participants recounted experiences of being able to carry out activities of daily living and maintain positive selfcare practices because of the help they received from the community mental health nurses. Participants recounted being supervised and assisted by the community mental health nurses to maintain personal and environmental hygiene as well as eating and grooming. This is what participants had to say in relation to this: *'They see to it that I am able to carry out activities of daily living such as eating on time, being able to wash and bath.'* (3F). As a result of the support participants received from the community mental

health nurses, they were now able to carry out activities of daily living, including shopping, on their own without any supervision as emphasized by the participants in their comments in this regard: *'Yes, now I can eat well and clean my surroundings.'* (3F); *'No, my family and I all do house chores together.'* (11F); *'Since they started coming, I am able to go on and do my everyday activities normally. I am now able to go to the shop.'* (5F). This made some of them to feel good and happy about their ability to function well. One participant who was now able to start selling oranges explained that she felt useful as a person evidenced by her comment as *'Okay formerly, I used not to bath but now I bath so I feel good and I am very happy.'* (3F); *'Yes, I am able to do a lot of things for myself. I even sell oranges in front of the house during the evening. So, I feel very useful.'* (2F). Similarly, those who were not even physically fit, were now able to move round and about their daily activities due to the support received from the community mental health nurses: *'At first I wasn't able to stand and move around, but now I am able to go around and go on my daily activities.'* (7F).

Appetite

Participants explained that they are now able to maintain good nutrition. One participant explained that she was now able to modify her diet and maintain a healthy weight based on advice from the community mental health nurses. Here, this what participants mentioned: *'Now able to sleep and eat well. At first, I couldn't eat well.'* (7F); *'Yes, now I can eat well ... Formerly I looked obese, but they've been able to modify my diet to maintain a healthy weight. They see to it that I am able to carry out activities of daily living such as eating on time'* (3F). One participant also resorted to regular exercise based on the advice of the community mental health nurses to maintain a healthy body weight. He states, *'The nurses told me to exercise a lot. So, I got more refreshed in my body and exercise, and I eat good food too.'* (2F).

Overall physical health

Participants account of their overall physical fitness showed that they felt strong and healthy and felt good about their physical health and the way they looked. Those who were physically unable to move were now able to move around their homes and others felt physically strong and able to do everything on their own. In this regard they mention the following in their comments: *'Now I can walk around the house.'* (4M); *'Formerly, I wasn't to do any work but now I am able to do everything on my own. Thanks to the nurses.'* (7F); *'I feel strong and healthy now.'* (4M); *'I have become nice. Formerly I wasn't well but now feel good and okay. I'm fine.'* (7F).

DISCUSSION

Introduction

This comprises assessment of the meanings and the implications of the findings from the current study viz-a-viz existing literature. Differences and similarities in the findings from the current study compared to that of already existing literature have also been highlighted. The discussion of the findings has been organised according to the constructs of Betty Ferrell's quality of life model.

Socio-demographic Characteristics of Respondents

A total of 11 patients took part in the study with their ages ranging from 21 to 52 years old. This indicates a fair representation of participants from a variety of age ranges. Thus, including young adults, the middle aged and the elderly. Seven of them were females and four of them were unemployed. The unemployment

may be linked to incapacitation as a result of mental illness or stigma against persons with history of mental illness (Buerthey *et al.*, 2020). All of them had some form of formal education. An indication of some form of literacy among the participants. Six of them had mood related disorders which can be linked to the increasing incidence of mood disorders in Ghana (Brinda *et al.*, 2016). Most of the participants had had history of mental illness for more than 5 years as such could give good account of their encounter with community mental health nurses and its effect on their quality of life.

Physical well-being

One of the objectives of the study was to explore the influence of community mental health care services on the physical wellbeing of persons with history of mental illness. Participants gave account of the influence that their community mental health nurses had on their compliance with prescribed drug regimen, activities of daily living, nutrition and their overall physical health. Participants recounted that community mental health nurses were very instrumental in ensuring their commitment to their prescribed drug regimen. They explained that the nurses showed keen interest by educating them on their drugs and counselling them on the need to adhere to their drug regimen. Liana and Windarwati (2021) also reported that community mental health workers play an essential role in explaining the purpose and use of psychotropic medications to persons with mental illness. These actions yielded results which improved the physical and mental state of the participants. This suggests that the community mental health nurses can stick to their mandate to of ensuring continuous nursing care to patients who have been treated and discharged (Thornicroft *et al.*, 2016).

In the current study, participants were supported and encouraged by the community mental health nurses to take their medications judiciously and according to prescription. The nurses followed up to supervise the participants to take their medications at home. These are evidence of good and trusting relationship between the community mental health nurses and the participants, allowing the participants to be comfortable and more open in telling the problems they are facing with regard to adherence to medication regimen, for them to be helped (Liana & Windarwati, 2021). This helps to ensure adherence to treatment regimen to reduce relapses among the patients (McTiernan & McDonald, 2015).

Furthermore, to be able to function and be independent, the community mental health nurses supervised and assisted their patients to maintain personal and environmental hygiene as well as eating and grooming. This is a way to provide care for the patients in their home setting. Thus, an indication that they bring the hospital to the patients' homes and allow for easy access to health care (Yeh, Liu, & Hwu, 2011). Due to this, participants were now able to carry out activities of daily living, including shopping, on their own without any supervision. These activities help in promoting independence of patients from their carers which also promotes their general quality of life. By so doing, some participants were able to resume their business activities and felt worthy one more time. Others who were physically weak became ambulant. As part of the influence of interventions of community mental health nurses on the physical wellbeing of persons with history of mental illness was their influence on the state of nutrition of their patients. Community mental health nurses helped patients to improve upon their diet, eat well and engage in physical exercises to get fit physically. This suggests a mirror of the hospital environment in the community, and which confirms that community mental health nurses serve as a crucial bridge between the patients and the hospital (Fournier, 2011).

As a result of the interventions carried out by the community mental health nurses to improve upon participants adherence to drug regimen, functional ability and nutrition, the participants felt strong and healthy and had good feelings about their physical health and the way they looked.

Psychological well-being

Community mental health nurses also contributed to the psychological wellbeing of the participants in the current study. This includes improvement in their memory, mood, assertiveness, and overall perception about quality of life. This agrees with the findings from a study in India where school mental health services were associated with an improvement in the psychological wellbeing of students (Sidana, 2018). Particularly, community mental health nurses helped in the improvement in the way participants felt about themselves. Negative emotions such as anxiety and depression among were either a reaction to the symptoms of mental illness or actual representation of the mental illness participants had. Frequent visits and engagement with community mental health nurses helped in the resolution of these feelings of depression and anxiety. Improvement in the mood of persons with mental illness due to interventions by community mental health nurses is also reported in a study in Pennsylvania where depression was significantly reduced among the patients in the first three months of their receiving community mental health care services (Hanrahan *et al.*, 2011). This confirms the assertion of Liana and Windarwati (2021) that community mental health nurses can provide comfort and reduce participant depression through education and optimal psychological intervention.

Secondly, services from the community mental health nurses also improved the memory and attention of some participants in the current study. Participants recounted that education and counselling services provided by the community mental health nurses helped them to gain some insight into their condition. Others also indicated evidence of memory improvement which may be due to their adherence to drug regimen because of supervision and encouragement from the community mental health nurses (Fournier, 2011).

In addition, engagement with their community mental health nurses through their frequent visits and encouragement increased confidence among the participants in the current study. Participants explained that they become more confident, assertive and could now mingle with people and express themselves better. This suggests learning taking place among the participants through their interaction with the community mental health nurses. Being assertive also helps participants to protect themselves from being exploited, stigmatised and discriminated because of their mental illness (Buertey *et al.*, 2020).

Furthermore, the symptoms of mental illness and the challenges that came with it, including stigma and discrimination obviously had negative impact on the quality of life of persons with history of mental illness. However, participants had a change in their overall perception about their quality of life and begun to feel good about themselves after there was a general improvement in their quality of life which was facilitated by their community mental health nurses.

Spiritual wellbeing

Community mental health nurses did not only influence the physical and psychological wellbeing of people with history of mental illness in the community but, also their spiritual wellbeing. In this study participants recounted experiences with community mental health nurses that improved their spiritual wellbeing. After coming to the realization that life experiences were characterised by good and bad times and that one needed to appreciate how to handle these events, participants drew some inspiration from the

community mental health nurses. Thus, an indication of the usefulness that community mental health nurses can be to the spiritual life of persons with history of mental illness. In fact, the interactions that participants had with their community mental health nurses gave them the opportunity to come to the realization that life meant more than getting overly concerned about a disease condition. Becoming overly concerned about the disease has negative impact on spiritual life as well as the mood of people which obviously will affect the quality of life of such individuals (Meißner *et al.*, 2019). Some participants lost hope because of their mental condition. This may be linked to being overly concerned about one's health. Participants however, begun to see some positive aspects of their lives after some visits and interactions with the community mental health nurses. Visits from community mental health nurses provide the opportunity for them to interact with patients in the community and help them address concerns about their health at home in the community (Buertey *et al.*, 2020). Consequently, the hopes of the participants were rejuvenated, and they had good reasons to live and look forward to a better life. Thus, an indication that community mental health nursing care helps in improving quality of life and wellbeing of persons with history of mental illness in the community (Eaton & Ohene, 2016).

After attaining some meaning in life and the motivation to look forward to a better life, they came to the realisation of the need to have an aim or a purpose in life to reach out to. Have some sense of purpose in life helps one to get some meaning in life which is very key to the improvement in the quality of life of a group of people. Helping people with history of mental illness to achieve this meaning in life underscores the important role of community mental health nurses as partners, support persons, counsellors, and teachers in the lives of people with history of mental illness (Liana & Windarwati, 2021).

Additionally, as a part of their spiritual life, participants experienced from their engagement with the community mental health nurses. Participants were drawn closer to God due to the spiritual upliftment they had whilst engaging with the community mental health nurses. Thus, an indication of positive changes in their spiritual lives. Improvement in the spiritual lives of people with history of mental illness was found to be positively correlated with self-perceived health, negatively associated with depression, and significantly mediated the relationship between depression and self-perceived health (Salman & Lee, 2019). Frustrations about their mental illness made some of the participants question why God will allow this to happen to them. Consequently, some had to even stop going to church because they found no reason to do so. However, after receiving some visits from the community mental health nurses, their perception about their condition changed. This further changed their attitude towards God positively.

Although some of the participants recounted being frustrated about the symptoms of their mental illness to the extent of questioning why God would allow this to happen to them, they later had a renewal of mind and later changed their attitude after engaging with the nurse. They began to trust God the more and prayed to God for healing whilst taking their psychotropic medications concurrently. This shows that having a sense of peace with God in the spirit encourages people with history of mental illness to comply with prescribed treatment regimen whilst trusting God to use that as a medium to heal them. As a result of this, being at peace with God, led to positive changes in the spiritual lives of the participants. Those stopped religious activities because of their mental illness resumed these activities after regaining their belief in God due to their engagement with the community mental health nurses. This included going to church more and listening to sermons for inspiration. This suggests and effective extended roles of the community mental health nurse in the spiritual lives of their clients.

Some participants became very active in church by taking on some roles in church. They joined Bible study groups in church. One also became a deaconess and she also helped in cleaning of the church

premises. This is evidence of improvement in their independence and social connectedness with people within their religious fraternity. The results of this study can also be linked to a similar study in Australia where persons living with mental illness confessed that the mental health care service given to them enhanced their independence and facilitate social connectedness (Heslop *et al.*, 2016).

Social well-being

The positive changes in the spiritual lives of the participants were also manifested in their social wellbeing. This was evidenced in their interactions with family, community members and church members. Some participants used to stay at home and avoided interacting with people. This was either as a symptom of their mental illness or as a reaction to their mental illness. The results of this study agree with the findings of Crabb *et al.* (2012) that the negative effects of mental illness may lead to guilt, concealment, isolation, and segregation. However, their encounter with the community mental health nurses changed the way they interacted with people. Participants were now able to come out to express themselves and interacted freely with people because of their engagement with the community mental health nurses. They were now able to overcome their shy and withdrawn behaviour due to the role the mental health nurses played in facilitating the development of their social skills. This kind of support enables social inclusion of the participants and their ability to communicate hope.

Consequently, people who used to avoid the company of the participants and were uncomfortable getting along with them begun to draw closer. The stigma associated with mental illness generates their feelings of shame, low self-esteem, isolation and hopelessness among people with mental illness. This explains why their friends avoided their company due to their mental illness. With the help of the community mental health nurses in promoting their physical and spiritual wellbeing, friends who avoided them now got along with them to the extent of watching television with them together.

Moreover, participants attributed the poor attitude of people towards them to the lack of understanding about mental health and mental illness. These forms of stigmatizing attitudes are stereotypes or negative opinions about people with mental illness which can lead to increased depression, reduced hopefulness, and self-esteem (Abiri *et al.*, 2016). Fortunately, health education and community sensitization activities carried out by the community mental health nurses contributed to some change in community perception and attitude towards the participants. These positive changes in community perception and attitude towards some of the participants had been a great relief to them.

On the other hand, interaction with their community mental health nurses helped the participants to relate well with others. This interaction is however known to pose some risk of associative stigma to the community mental health nurses (Lin *et al.*, 2019). Community mental health nurses therefore need to be ready to confront such situation during the dispensation of their duties. The intervention of the community mental health nurses also improved relationship between participants and their community members, church members as well as their family members. Regarding community members, participants recounted an improvement in their attitude towards them improved because of the intervention of the community mental health nurses. Some participants who went out of business because they were stigmatized by community members had their businesses getting started again based on a change in the attitude of community members towards them. This was attributed to community sensitization activities carried out by the community mental health nurses. Community mental health nurses are known to educate the public on mental health through health talks at Outpatient Departments (OPD), Schools and Organizations. Their services extend to family members, friends and all those who encounter the mentally ill (Stanhope and

Lancaster, 2019). This was also coupled by treatment interventions received from the community mental health nurses which improved upon the mental state of the participants in the current study.

Furthermore, the interaction of participants with the community mental health nurses also improved upon their own interactions with their community members as well. Thus, they were able to learn some social skills which they applied in their relationship with community members. These help in the total recovery and improve in the quality of life of persons with history of mental illness. According to literature, recovery from mental illness is, in essence, a personal and unique process and experience, but it often unfolds within a social and interpersonal context (Svavarsdottir *et al.*, 2014).

Relationship between participants and their church members also improved. All participants in this current study were Christians. This explains why the influence of mental illness on their church lives were unearthed. Some participants were active church members but had their roles disrupted by mental illness. However, as their symptoms improved and they continued to interact with their community mental health nurses who encouraged them to resume their church roles, they begun to see a general positive improvement in their wellbeing. This finding confirms Turton *et al.* (2011) that recovery does not mean that all symptoms of mental health illness are eliminated but is about improving well-being and regaining a role as a citizen.

In addition, participants who had problems relating with their family members because of their mental illness also had some relief due to their engagement with the community mental health nurses. Some participants were stigmatized by their own family members due to their mental illness. In fact, their own family members avoided company with them and even denied accepting them as a part of them. These situations are as a result of lack of knowledge and understanding among mental health and mental illness on the part of the perpetrators of such stigmatising and discriminatory attitudes (Buertey *et al.*, 2020). Fortunately, the community mental health nurses, through education and counselling of both client and family helped to resolve these unfortunate relationship problems between persons with history of mental illness and their own relatives. As result of this, their relatives begun to understand the mental health condition of the participant and had a change in attitude by drawing closer to the participants and interacting with them. Participants who were rejected were now accepted by their families as a part of them. This allowed them to take part in their family gatherings and activities and their opinions were now being heard. Furthermore, relatives begun to interact well with them and showed concern about their medications and treatment in general. These are evidence of transformation in the lives of people with history of mental illness based on the intervention of their community mental health nurses. Invariably this contributed a lot to the promotion of their social wellbeing.

Summary

The positive influence of interventions of community mental health nurses in the physical, psychological, social, and spiritual lives of persons with history of mental illness is evident in this study and in existing literature. Visits from community mental health nurses provided opportunity for them help patients with history of mental illness to stick to drug regimen, regain their confidence and self-worth and improve upon their spiritual lives as well as their relationship with people.

CONCLUSIONS AND RECOMMENDATIONS

Introduction

Conclusions

Influence of community mental health care services on spiritual wellbeing

Spiritual wellbeing represented meanings that participants got about life and their hopes and expectations for a better life through the intervention of the community mental health nurses. These included experiences on drawing closer to God, becoming more spiritual and experiencing some positive changes in ones' life. Thus, becoming more active in church activities were narratives about the spiritual wellbeing of the participants. This was described in terms of having hope in God for cure, experiencing spiritual transcendence and positive changes in one's life such becoming more active in religious activities.

Influence of community mental health care services on social wellbeing

Findings on the influence of community mental health care services on the social wellbeing of persons with history of mental illness represents the impact of community mental health nursing activities on the quality of the nature of their relationships with people around them. These relationships include improved ability to interact freely with people because of their engagement with the community mental health nurses as well as a positive change in the attitude of people towards them. Community mental health nurses also facilitated positive relationships between their clients and the members of their families by helping to understand the clients and drawing closer to them. This extended to improved client relationships with their church members and their community members.

Influence of community mental health care services on psychological wellbeing

About the influence of community mental health care services on the psychological wellbeing of persons with history of mental illness, the study revealed an improvement in the insight of the clients into their condition as well as their memory. Changes in mood including relief of anxiety and depression were reported in addition to improvement in level of confidence and assertiveness. Clients could now mingle with people and express themselves better could master the courage to confront people who tried to take advantage of them because of their mental condition. Others educated their community members about mental illness.

Participants also gave a self-appraisal of the changes and relief of symptoms of their mental illnesses. There was also a change in their perception of overall quality of life. Those who used to feel bad about themselves now felt good about themselves through the supply of medication and counselling services they received from the community mental health nurses.

Influence of community mental health care services on physical wellbeing

Findings on the influence of community mental health care services on the physical wellbeing of persons with history of mental illness showed improvement in their physical health in addition to positive lifestyle changes. These included improved compliance with prescribed medication regimen. The nurses paid attention to their medication regimen, and they were educated and counselled on the need to take their medications and the importance of their medication to them.

Secondly, the clients experienced improved ability to carry out activities of daily living. They recounted experiences of being able to carry out activities of daily living and maintain positive selfcare practices because of the help they received from the community mental health nurses including the maintenance of

good personal and environmental hygiene as well as eating and grooming. This led to improved nutrition and an increase in overall physical health. Clients were now able to modify her diet and maintain a healthy weight based on advice from the community mental health nurses. Consequently, they felt strong and healthy and felt good about their physical health and the way they looked.

REFERENCES

1. Abiri, S., Oakley, L.D., Hitchcock, M.E. & Hall, A. (2016). Stigma Related Avoidance in People Living with Severe Mental Illness (SMI): Findings of an Integrative Review. *Community Mental Health Journal*, 52 (3), 251-261.
2. Adu-Gyamfi, S. (2017). Mental Health Service in Ghana: A Review of the Case. *International Journal of Public Health Science (IJPHS)*, 6 (4), 299-313.
3. Bassah, N., Ubenoh, U. S., & Palle, J. N. (2018). Gerontology & Geriatric Research An Exploratory Study of the Knowledge and Practices of Family Caregivers in the Care of the Elderly at Home in the Buea Health District , Cameroon. *J Gerontol Geriatr Res.*, 7(3), 3–7. <https://doi.org/10.4172/2167-7182.1000473>
4. Bernardino, L., Ivo, M. L., Souza, A. S. de, Pontes, E. R. J. C., Pinto, A. M. A. C., & Araujo, R. O. M. (2012). The burden and quality of life of caregivers of sickle cell anemia patients taking hydroxyurea versus those not taking hydroxyurea. *Rev Bras Hematol Hemoter*, 34(4), 270–274. <https://doi.org/10.5581/1516-8484.20120070>
5. Brinda, E. M., Rajkumar, A. P., Psych, M. R. C., Jø', J., Attermann, J., Gerdtham, U. G., Enemark, U., & Jacob, K. S. (2016). *Health, Social, and Economic Variables Associated with Depression Among Older People in Low- and Middle-Income Countries: World Health Organization Study on Global AGEing and Adult Health*. <https://doi.org/10.1016/j.jagp.2016.07.016>
6. Buertey, A. A., Attiogbe, A., & Aziato, L. (2020). Stigma by association: Experiences of community psychiatric nurses in the Accra Metropolis, Ghana. *International Journal of Africa Nursing Sciences*, 13. <https://doi.org/10.1016/j.ijans.2020.100260>
7. Corrigan, P.W., Roe, D., & Tsang, H.W.H. (2011). *Challenging the stigma of mental illness: Lessons for therapists and advocates*. Chichester, West Sussex: Wiley-Blackwell.
8. Crabb, J., Stewart, R.C., Kokota, D., Masson, N., Chabunya, S. & Krishnadas, R. (2012). Attitudes towards mental illness in Malawi: A cross-sectional survey. *BMC Public Health*, 12 (1), 10.1186/1471-2458-12-541
9. Dawson, C. P. (2018). *Economic Burden and Quality of Life of Primary Caregives of Lymphoma Patients Attending the Paediatric Cancer Unit at Komfo Anokye Teaching Hospital (Issue July)*. University of Ghana.
10. Eaton, J. & Ohene, S. (2016). *Providing Sustainable Mental Health Care in Ghana: A Demonstration Project*. National Academies Press (US); Washington (DC).
11. Ferrell, B. R., Grant, M., & Dow, K. H. (1995). Measurement of the quality in cancer survivors. *Quality of Life Research*, 4, 523–531.
12. Ferrell, B. R., Grant, M., & Hassey-Dow, K. (1999). *Quality of Life Model Applied to Cancer Survivors*. City of Hope Pain & Palliative Care Resource Centre.
13. Fournier, O.A. (2011). The status of mental health care in Ghana, West Africa and signs of progress in the greater Accra region. *Berkeley Undergraduate Journal*, 24 (3).

14. Hanrahan, N. P., Wu, E., Kelly, D., Aiken, L. H., & Blank, M. B. (2011). Randomized Clinical Trial of the Effectiveness of a Home-Based Advanced Practice Psychiatric Nurse Intervention: Outcomes for Individuals with Serious Mental Illness and HIV. *Nursing Research and Practice*, 2011. <https://doi.org/10.1155/2011/840248>
15. Heslop, B., Wynaden, D., Tohotoa, J., & Heslop, K. (2016). Mental health nurses' contributions to community mental health care: an Australian study. *International Journal of Mental Health Nursing*, 25(5), 426–433.
16. Janodia, M. D. (2016). Health Related Quality of Life (HRQOL) Measures in Healthcare Delivery System : *Indian Perspective. J Young Pharm*, 8(3), 164–167. <https://doi.org/10.5530/jyp.2016.3.1>
17. Karimi, M., & Brazier, J. (2016). Health, Health-Related Quality of Life, and Quality of Life: What is the Difference? *PharmacoEconomics*, 34(7), 645–649. <https://doi.org/10.1007/s40273-016-0389-9>
18. K. Milner et al (2020) . The experiences of spirituality among adults with mental health difficulties: a qualitative systematic review
19. Khan, J. A. (2012). *Research Methodology*. New Delhi: Balaji Offset.
20. Kusi, H. (2012). *Doing Qualitative research-A guide for researchers*. Accra-New Town: Emmpong Press.
21. Lavdaniti, M., & Tsitsis, N. (2015). Definitions and Conceptual Models of Quality of Life in Cancer Patients. *Health Science Journal*, 9(26), 1–5.
22. Liana, L., & Windarwati, H. D. (2021). The effectivity role of community mental health worker for rehabilitation of mental health illness: A systematic review. *Clinical Epidemiology and Global Health*. <https://doi.org/https://doi.org/10.1016/j.cegh.2021.100709>.
23. Lin, X., Rosenheck, R., Sun, B., Xie, G., Zhong, G., Tan, C., Li, Z., Yu, M., He, H. (2019). Associative stigma experienced by mental health professionals in China and the United States. *Social Psychiatry and Psychiatric Epidemiology*, 54 (6), 745-753.
24. Litwin, M. S. (2010). Health-Related Quality of Life. In *Clinical Research for Surgeons* (pp. 233–251). Humana Press Inc.
25. Madani, B. M., Raddadi, R. Al, Jaouni, S. Al, Omer, M., & Awa, M.-I. Al. (2018). Quality of life among caregivers of sickle cell disease patients : a cross sectional study. *Health and Quality of Life Outcomes*, 16(176), 1–9.
26. Markle-reid, M., Mcainey, C., Forbes, D., Thabane, L., Gibson, M., Browne, G., Hoch, J. S., Peirce, T., & Busing, B. (2014). An interprofessional nurse-led mental health promotion intervention for older home care clients with depressive symptoms. *BMC Geriatrics*, 14(62), 1–23.
27. McTiernan, K. & McDonald, N. (2015). Occupational stressors, burnout and coping strategies between hospital and community psychiatric nurses in a Dublin region: Stressors, coping burnout. *Journal of Psychiatric and Mental Health Nursing*, 22 (3), 208-218.
28. Meißner, S., Wagner, K., Joos, A., Metternich, B., & Schulze-Bonhage, A. (2019). Emotional Reaction to viewing one's own epileptic seizure. *Seizure*, 64, 34–40. <https://doi.org/10.1016/j.seizure.2018.11.016>
29. Roberts, M., Mogan, C., & Asare, J. B. (2014). An overview of Ghana's mental health system: results from an assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS). *International journal of mental health systems*, 8, 16. doi:10.1186/1752-4458-8-16.

30. Salman, A., & Lee, Y. H. (2019). Spiritual practices and effects of spiritual well-being and depression on elders' self-perceived health. *Applied Nursing Research*, 48, 68–74. <https://doi.org/10.1016/j.apnr.2019.05.018>
31. Sidana, A. (2018). Community Psychiatry in India : Where We Stand ? *Journal of Mental Health and Human Behaviour*, 23(1).
32. Sim, J., Saunders, B., Waterfield, J. & Kingstone, T. (2018). Can sample size in qualitative research be determined a priori? *International Journal of Social Research Methodology*, 21 (5) 619-634, DOI: [10.1080/13645579.2018.1454643](https://doi.org/10.1080/13645579.2018.1454643)
33. Slade, M. (2010). Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC Health Services Research*, 10(26).
34. Stanhope, M. & Lancaster, J. (2019). *Public health nursing e-book: Population-centered health care in the community*. Elsevier Health Sciences. https://books.google.com.gh/books?hl=en&lr=&id=ct3WDwAAQBAJ&oi=fnd&pg=PP1&ots=eIXMAeX9Qp&sig=hkg5iTJuyi7S6TNA4fu2ZBOMV6g&redir_esc=y#v=onepage&q&f=false
35. Svavarsdottir, S.J., Lindqvist, R. & Juliusdattir, S. (2014). Mental Health Services and Quality of Life. *International Journal of Psychosocial Rehabilitation*, 18(2), 72-88.
36. Sveinsson, Ó. A., Thorleifsson, K., Aspelund, T. and Kolbeinsson, H. (2012). Research on coronary disease risk factors among schizophrenia patients in the mental ward at the National Hospital. *The Icelandic Medical Journal*, 98(7-8), 399-402.
37. Thornicroft, G., Deb, T. & Henderson, C. (2016). Community mental health care worldwide: Current status and further developments. *World Psychiatry*, 15 (3), 276-286, [10.1002/wps.20349](https://doi.org/10.1002/wps.20349)
38. Walker, J.L. (2012). The use of saturation in qualitative research. *Can J Cardiovasc Nurs.*, 22(2):37-46.
39. Yeh, L.-L., Liu, S.-K. & Hwu, H.-G. (2011). Needs and Demands for Community Psychiatric Rehabilitation Programs from the Perspectives of Patients and Caregivers. *Community Mental Health Journal*, 47 (4), 415-423.
40. Kakuma R, Kleintjes S, Lund C, Drew N, Green A, Flisher A. Mental Health Stigma : What is being done to raise awareness and reduce stigma in South Africa ? *Africa J Psychiatry*. 2010; 13:116–24.