

A situation analysis of mental health services and legislation in Ghana: challenges for transformation

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Abstract

Objective: To conduct a situation analysis of the status of mental health care in Ghana and to propose options for scaling up the provision of mental health care. **Method:** A survey of the existing mental health system in Ghana was conducted using the WHO Assessment Instrument for Mental Health Systems. Documentary analysis was undertaken of mental health legislation, utilizing the WHO Legislation checklists. Semi-structured interviews and focus group discussions were conducted with a broad range of mental health stakeholders (n=122) at the national, regional and district levels. **Results:** There are shortfalls in the provision of mental health care including insufficient numbers of mental health professionals, aging infrastructure, widespread stigma, inadequate funding and an inequitable geographical distribution of services. **Conclusion:** Community-based services need to be delivered in the primary care setting to provide accessible and humane mental health care. There is an urgent need for legislation reform, to improve mental health care delivery and protect human rights.

Key words: Mental health; Legislation; Ghana

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Introduction

Mental health care is often one of the lowest health priorities for low-income countries¹ and Ghana is no exception. In common with many low-income post-colonial countries in Africa, Ghana has not developed the infrastructure and public services, including mental health care, to keep pace with population expansion. The population of Ghana has more than doubled since independence in 1957² with a consequent

growth in the numbers of people suffering from mental disorders. Recent research has revealed the extent to which mental health care in many low and middle-income countries is consistently under-resourced.³⁻⁵ In the relative absence of community care, institutionalised care remains the norm for many of those with mental health problems in low-income countries.⁵ Indeed, in countries such as Ghana, many of those in need of treatment do not reach psychiatric services at all, but seek the care of informal community mental health services⁶ such as traditional and faith healers and family members who offer a varying quality of service and level of efficacy.

In addition, there is increasing evidence from developing countries that mental illness is strongly associated with

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poverty.⁷⁻⁹ Despite some significant economic growth in recent years, Ghana is classified as a low-income country with 28.5% of the population living in poverty, and 18.2% living in extreme poverty, especially in rural areas.¹⁰ Yet there is a growing body of research demonstrating innovative, cost-effective interventions for mental disorders such as schizophrenia and depression in low-income African countries.¹¹⁻¹³ Among these are agricultural rehabilitation villages in Tanzania¹⁴, family involvement in hospital care in Senegal^{15,16}, group therapy for the treatment of depression in Uganda¹⁷, and collaborations with traditional healers in northern Ghana.¹⁸ In Africa therefore, as in other regions of the world, the deficit is not in the evidence for interventions to address mental health problems, but in the resources and political will that can make these interventions available to those who need them.

Ghana currently stands in a relatively unique position within the African continent to respond to this challenge. In spite of its low-income status, the country has one of the highest literacy rates within West Africa (57.9%)¹⁹, is considered a relatively stable and peaceful democracy with good standards of governance, and has a strong and diverse civil society. As one of the first countries to gain independence in 1957, it was also one of the pioneers of primary health care in the region²⁰ and initiated early attempts to develop mental health care in the first years of independence with the establishment of new psychiatric hospitals and later the introduction of psychology, occupational therapy and community psychiatric nursing. Today, despite the shortage of specialist psychiatric personnel, Ghana remains relatively well-resourced for mental health care in comparison to other countries in the region.³

There have also been several attempts to respond to the call to develop mental health provision in primary care and to provide community-based mental health services. The training of community psychiatric nurses was instituted in 1976 when these nurses were posted to approximately half the districts in the country. Between 1994 and 1998 primary health care and development workers in the Upper West Region of Ghana were trained in mental health care, integrating mental health into primary care.²¹ Similarly, in 1998 the WHO Nations for Mental Health Project trained health volunteers to provide community support to patients with mental disorders.^{22,23}

Despite these innovations, a comprehensive situation analysis of the mental health system in Ghana has not yet been undertaken. This paper presents the results of a situation analysis of the current status of mental health policy and services in Ghana which was conducted as part of the first phase of the Mental Health and Poverty Project (MHaPP). The MHaPP, which is being conducted in four African countries: Ghana, South Africa, Uganda and Zambia, aims to investigate the policy level interventions that are required to break the vicious cycle of poverty and mental ill-health, in order to generate lessons for a range of low- and middle-income countries.²⁴ Based on the findings of the situation analysis, the paper presents proposals for transforming mental health care in Ghana to provide for the majority of those in need and to protect the human rights of patients and their families in a way which is culturally responsive and cost-effective within the budget of a low-income country.

Methods

The WHO Assessment Instrument for Mental Health Systems Version 2.2 (WHO AIMS)²⁵ was completed by the researchers with the aid of 48 key stakeholders in health and mental health care to provide an overview of mental health policy and services. Data for the WHO-AIMS was collected for the index year of 2005.

Documentary analysis of mental health legislation was conducted utilising the WHO Checklist for Mental Health Legislation²⁶, which is designed to assess the content and development of mental health legislation, according to a number of criteria. The checklist was completed by a team consisting of a clinical psychologist, a psychiatrist, a research officer, the national coordinator of community psychiatric nurses (CPNs), and the deputy director of nursing services at the Accra Psychiatric Hospital. Documents evaluated included: the 1972 Mental Health Decree²⁷, and the 2006 draft Mental Health Bill.²⁸

Eighty-one interviews and 7 focus group discussions were held with policy makers, health professionals, healers, users of psychiatric services, teachers, police officers, academics, and religious and traditional leaders drawn from five of the ten regions in Ghana. The interviews and focus group discussions were conducted with 122 respondents, who were purposively sampled from among the major stakeholders in mental health at the national, regional and district levels.

Semi-structured interview guides were tailored according to the specific individual being interviewed. Topics covered included general policy making process in Ghana, the process of mental health policy and legislation development, the role of stakeholders in mental health policy and legislation development, the content of the current mental health policy and legislation, and the implementation of mental health policy and legislation at the national and regional levels. Thirty-five interviews were held at the national level, and 23 at the regional level. One focus group discussion was held at the national level.

Interviews were digitally recorded with participants' consent and transcribed verbatim. Interviews in the local Ghanaian language (Twi) were first transcribed and then translated into English by staff of the Bureau of Ghana Languages. All transcripts were entered into Nvivo 7 which was used for coding and analysis. A framework analysis approach was adopted²⁹ in which certain themes were agreed upon by investigators from all four study countries based on the objectives of the study. From these objectives, sub-themes were suggested by country partners, and reviewed by all partners through a process of iteration, until a single framework was agreed upon that could be used by all four study countries. Where specific themes emerged from the interviews that were not included in the generic cross-country framework, these were added to the coding frame, to adapt the analysis to issues specific to Ghana. Transcripts were coded on the basis of these themes, with additional themes added to the coding framework as determined by the data. Interviews were coded independently for 10% of randomly sampled interviews to ensure inter-rater reliability. Inter-rater reliability was always above 90%.

Ethical approval was granted by the Ghana Health Service Ethics Committee and the Institutional Ethics Board at Kintampo Health Research Centre. Information sheets

containing essential information about the study and the implications of participation were given to all participants. Participants who were unable to read had a witness read the information sheet and consent form to them in Twi. Participants were requested to sign a consent form to indicate their willingness to participate in the study. Those participants who were unable to write were requested to provide a thumb print in lieu of a signature in the presence of a witness. The names and other identifying features of the respondents were removed from the transcripts in order to ensure confidentiality.

Results

Policy, governance and organisational structure

Policy is formulated at the ministerial level, and implemented through the Ghana Health Service (GHS). The Mental Health Unit which oversees mental health services, is placed under GHS's Institutional Care Division (see Figure 1). The Mental Health Unit acts as the national mental health authority, advising the government on mental health policies and legislation, and providing monitoring and quality assessment of mental health services. The Unit oversees the three government psychiatric hospitals, the psychiatric wings of the 5 regional hospitals, community mental health services, and private psychiatric facilities. Traditional and faith healers are also supposed to be under the supervision of the unit, however in practice there is little oversight.

Financing of Mental Health Services

It was reported that approximately 6.2 % of the health care budget of the Ministry of Health was dedicated to mental health in 2005. In addition to this, results of interviews with mental health professionals and Ministry of Finance officials indicated that due to the policy of decentralisation, funding is disbursed to Budget Management Centres at the regional and district levels some of which may be allocated to mental health. However there were no figures available on mental health expenditure at the district level.

The majority of the budget for mental health (nearly 80%) is allocated for the maintenance of the three psychiatric hospitals. Despite this, funding for the psychiatric hospitals was described by one psychiatric nurse as "woefully inadequate". Participants reported that funds are quickly absorbed in meeting the basic needs of patients, and the psychiatric hospitals often run out of sufficient funds to feed patients. Therefore little of the budget is available for psychosocial and rehabilitative interventions.

The National Health Insurance Scheme (NHIS) does not cover psychiatric services because by policy treatment for mental disorders is provided free of charge at the government psychiatric hospitals and through community psychiatric nurses. However if these are not accessible, or medication runs out as can occur, then patients have to purchase these privately without recourse to a refund. Many psychiatric patients who do not have health insurance are not covered for treatment of co-morbid physical conditions.

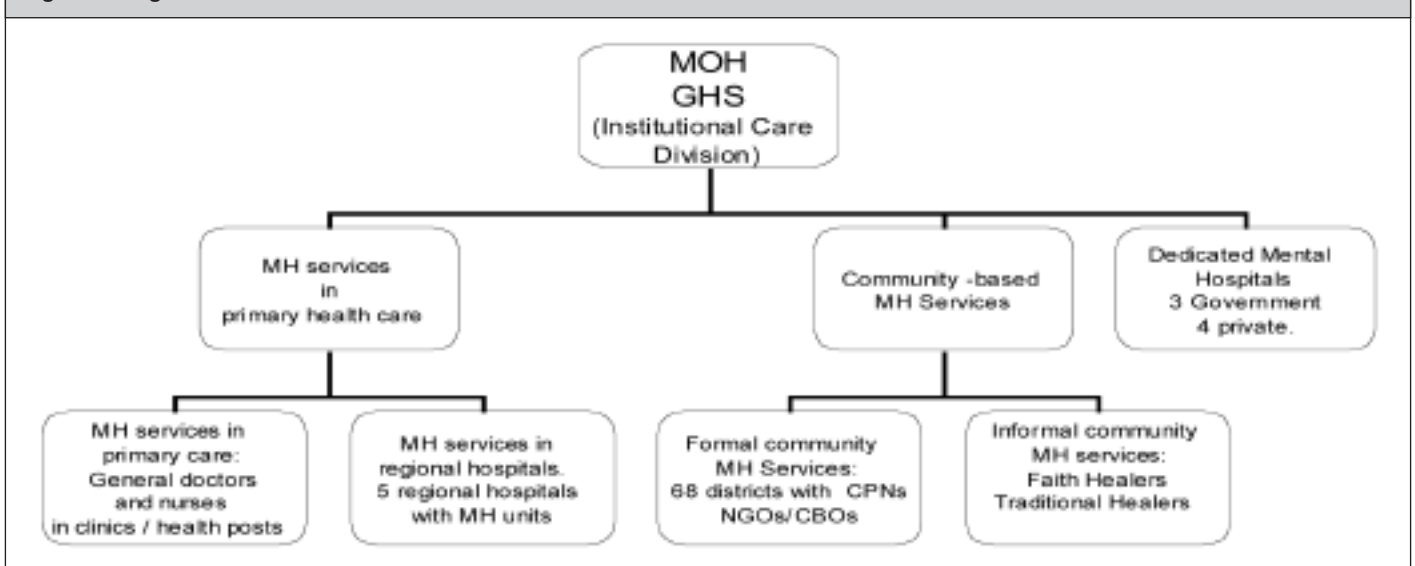
Mental health services

Inpatient care

There are three government psychiatric hospitals in Ghana providing 7.04 beds per 100,000 population. Accra and Pantang Psychiatric Hospitals are located in Accra, and Ankaful Psychiatric Hospital is in the Central region. There are 4 private psychiatric institutions which provide outpatient clinics and inpatient care. Two are located close to Accra and two near the second largest city of Kumasi. There are psychiatric in-patient units in 5 of the 10 regional general hospitals in the country providing a total of 77 beds (0.33 beds per 100,000 population), with the number of beds per unit ranging from 10 to 22. The ratio of psychiatric beds in the mental hospitals in or around Accra, the capital, to the total number of beds in the rest of the country is 6.28 to 1, indicating a concentration of inpatient resources in urban areas.

There were 6,605 admissions to the three state psychiatric hospitals in 2005. Approximately 50% of these were female. It is likely that this number may include repeat

Figure 1: Organisation of mental health services in Ghana.



admissions due to the failure to capture unique patient identifiers in the health information system. The state psychiatric hospitals are chronically overcrowded by as much as a third more patients than beds.

Inpatient stays are frequently lengthy which exacerbates the pressure on hospital beds (Table I). One of the reasons for such long admissions is the stigma attached to mental disorders, which can result in relatives or caregivers abandoning the person at the psychiatric hospitals. Secondly, while the individual is in the care of the hospital they receive free board and lodging, as well as treatment. This can prove an attractive benefit for both the patient and the family, particularly those with limited financial means. In addition, due to the absence of secure hospitals and the inefficiency of the legal system, some offenders who have been ordered by the courts to be admitted for a psychiatric assessment can remain in the psychiatric hospitals for many months.

Table I: Number of beds and length of inpatient admission to psychiatric hospitals.

Hospital	Bed capacity	Average length of hospital admission	Number of long stay patients*
Ankaful	250	82.2 days	Not available
Pantang	500	285 days	205
Accra	800	Not available	520

*patients who have recovered but remain in hospital

Psychotic disorders are the most frequent in-patient diagnosis in the psychiatric hospitals, followed by substance use disorders and mood and affective disorders (Table II). Neurotic disorders are rarely diagnosed and recorded. There are also many cases with unspecified diagnoses. There are difficulties interpreting the data as diagnosis is frequently not standardised, according to several stakeholders who were interviewed.

Outpatient care

A total of 86,003 service attended the outpatient departments at the three psychiatric hospitals in 2005 (Table III). There is some overlap in these statistics since some patients attend more than one psychiatric hospital.

Table III: Outpatient attendance by gender at psychiatric hospitals in Ghana, 2005.

Hospital	Male	Female	Total
Accra	20,462	23,682	44,211
Pantang	6,922	5,963	12,885
Ankaful	N/A	N/A	28,907
Total	N/A	N/A	86,003

(N/A = not available)

Sub-Specialist services

There are no dedicated outpatient facilities for child and adolescent mental health in Ghana. A total of 2,578 patients under the age of 19 years were seen at all three hospitals. There are 45 dedicated inpatient beds for children and adolescents in the psychiatric hospitals, representing 4% of the total. There are 10 residential facilities for children under 17 with intellectual disabilities, one in each of the regions. In addition, a non-governmental organisation (NGO) provides residential care and rehabilitation in the Brong Ahafo region for children with intellectual disabilities. There is also a private school for children with intellectual disabilities in Accra. There are dedicated beds for older people at the Accra Psychiatric Hospital. However there are no specialised mental health services for older people, or people with dementia.

In Accra psychiatric hospital there is a dedicated forensic ward with 15 beds and more than 300 patients. However this is not used solely by forensic patients. In Pantang hospital in 2005, there were 88 forensic patients. There are 2 private residential facilities for people with substance abuse and one private hospital in Accra has a detoxification unit.

Rehabilitation, residential and day services

There are very few rehabilitation and day services for people with mental disorders. Those which exist are largely run by NGOs and faith-based organisations. There are 15 beds in an inpatient rehabilitation facility which forms part of Ankaful psychiatric hospital and 6 community residential facilities run by voluntary and church organisations which provide drug rehabilitation. Cheshire Home in Kumasi provides residential rehabilitation and vocational training for up to 55 adults with

Table II: Inpatient diagnoses at psychiatric hospitals in Ghana, 2005.

Diagnosis	Accra	Pantang	Ankaful	Total	%
Mental and behavioural disorders due to psychoactive substance use (F10-F19)	808	338	362	1508	22.8%
Schizophrenia, schizotypal, and delusional disorders (F20-F29)	1442	516	511	2469	37.4%
Mood, affective disorders (F30-39)	605	138	510	1253	19.0%
Neurotic, stress-related and somatoform disorders (F40-F48)	0	0	0	None recorded	
Disorders of adult personality and behaviour (F60-F69)	0	0	0	None recorded	
Others*	1232	86	57	1375	20.8%
Total				6605	100%

*includes epilepsy, dementia, other organic disorders, and unspecified

mental disorders. More recently the NGOs Basic Needs and Christian Blind Mission have established three community-based rehabilitation projects for people with mental disorders in the north of Ghana.

There are three known day treatment facilities in Ghana run by NGOs or church organisations. The Damien Centre at Takoradi in the southwest of the country is run by the Catholic Church. Two drop-in facilities for vagrants are provided in Tamale in the Northern region based on the club house model: Tsi-sampa run by Basic Needs, and Shekina, run by a private practitioner. There are no day treatment facilities run by GHS.

Mental health in primary health care

Doctors provide primary mental health care through the outpatient departments of the hospitals. Most government clinics in the sub-districts do not employ doctors, but are staffed by medical assistants or nurses, or by personnel with lower levels of training such as community health workers or community midwives. Medical assistants provide assessment, diagnosis and treatment, including prescribing and administering medication, and effectively work in a physician role. There are no specialist doctors in mental health in primary health care clinics in Ghana. In spite of the unavailability of physicians in primary health care clinics, there are assessment and treatment protocols in most of these clinics which include guidance on the treatment of the major psychiatric conditions including schizophrenia and depression.³⁰

Data on psychiatric morbidity in outpatient consultations at district health facilities is collated at the regional level under four psychiatric categories: epilepsy, acute psychosis, neurosis, and substance abuse (Table IV). However, these data are likely to be a significant underestimate of the true incidence since many districts lack psychiatric professionals and do not collate data on psychiatric disorders. Differences between regions are therefore more likely to be due to differences in recording of cases, than to true differences in morbidity.

Between 21-50% of primary health care clinics are estimated to refer patients presenting with mental disorders to a higher level of care, such as the psychiatric units of the regional hospitals, or the psychiatric hospitals in Accra or Cape Coast. Communication and collaboration between primary health care workers and psychiatric

services is poor and the physical health needs of the mentally ill are often neglected. Between 1-20% of workers in the district hospitals and primary health care clinics are estimated to have had contact with a traditional or faith healer. However, no records of such contacts are maintained. Collaboration with traditional or faith healers tends to be informal and is largely undocumented.

Training in mental health care for primary care staff

Seven percent of the training for medical doctors is devoted to mental health. General nurses undertake six weeks affiliation at the psychiatric hospitals as part of their training. Post-basic medical assistants receive only one week's training in mental health. Some training of primary health care workers in mental health has been facilitated by Basic Needs and an outreach team from Ankaful Psychiatric Hospital.

In terms of refresher training, there were no data available on how many primary health care doctors and non-doctor/non-nurse primary health care workers had received refresher training in mental health in the index year of 2005. However, responses from the qualitative data indicated that in-service training in psychiatry is limited. Many of the primary health care workers interviewed stated that they have had no training in psychiatry since they completed their initial clinical training.

Psychotropic medication

All mental hospitals, psychiatric units in general hospitals, and outpatient mental health facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility in 2005. However the range of psychotropic medication available within GHS is limited largely to older generic drugs. The new generation of anti-psychotics and anti-depressants, as well as mood stabilising drugs such as Lithium and Sodium Valproate, are not widely available, despite the inclusion of Sodium Valproate and Risperidone in the Essential Medicines List.³¹ There is limited availability of depot anti-psychotic medication within Ghana Health Service, especially outside the psychiatric hospitals.

In the qualitative interviews, several respondents indicated that the supply of psychotropic drugs to inpatient and community facilities is often insufficient, leading to shortages of essential medication. When medication is unavailable at the hospital pharmacies and clinics, patients must purchase the necessary medication at their own expense.

Table IV: Outpatient psychiatric service utilisation per region, 2005.

Disorder	WR	CR	GAR	VR	ER	ASH	BAR	NR	UER	UWR	Total
Epilepsy	868	200	929	911	581	1,239	737	733	1,005	458	7,661
Acute Psychosis	194	123	1,607	1,612	755	1,044	1,065	221	645	184	7,450
Neurosis	288	276	524	304	431	4,101	660	108	332	103	7,127
Substance Abuse	443	139	739	269	482	1,452	261	84	333	119	4,321
Total new cases	1,793	738	3,799	3,096	2,249	7,836	2,723	1,146	2,315	864	26,559

Data collated from returns submitted by district level facilities.

Key to regions: WR= Western, CR= Central, GAR= Greater Accra, VR= Volta, ER= Eastern, ASH=Ashanti, BAR= Brong Ahafo, NR= Northern, UER= Upper East, UWR= Upper West

Human rights protection

There is no national body to oversee regular inspections in mental health facilities, to review involuntary admission and discharge procedures, to review complaints, investigation processes and to impose sanctions (e.g. withdraw accreditation, impose penalties, or close facilities that persistently violate human rights). As a result, none of the mental hospitals nor the inpatient psychiatric units and community residential facilities had any review or inspection of the human rights protection of patients in 2005. However in the following two years of 2006 and 2007, there were inspections of the psychiatric hospitals by the Commission for Human Rights and Administrative Justice, and in 2008 the Parliamentary Sub-Committee on Health also inspected two of the three state psychiatric hospitals. There was no training in the protection of the human rights of patients in the inpatient psychiatric units and community residential facilities in 2005.

Human resources in mental health care

In 2005 the human resources for mental health care were: 15 psychiatrists, 468 psychiatric nurses, 132 community psychiatric nurses (CPNs) based in the ten regions covering 69 of the 138 districts, 7 psychologists, 10 medical assistants, 6 social workers, and 1 occupational therapist. Nine of the psychiatrists working in GHS are officially retired. The distribution of psychiatric nurses per 100,000 of the population is 6.29 times greater in Accra than in the entire country. The low numbers of psychologists and occupational therapists is largely attributable to the fact that GHS does not hire psychologists and has no training for occupational therapists.

Training professionals in mental health

The number of health professionals who graduated from health training institutions in 2005 is as follows: approximately 190 medical doctors (not specialized in psychiatry), no psychiatrists, 150 nurses with at least 1 year training in mental health care, approximately 7 psychologists with at least 1 year training in mental health care, and 35 medical assistants (not specialised in psychiatry).

Public education and awareness campaigns on mental health

Mental health professionals and NGOs have conducted a few public education and awareness campaigns in mental health in the last five years, such as World Mental Health Day and the 100th anniversary of the Accra Psychiatric Hospital in 2006. The NGO Mindfreedom has held two 'Mad Pride' marches in Accra in 2006 and 2007 to raise awareness of mental health and promote the rights of mental health service users. Several respondents reported conducting occasional educational talks on mental health in schools and churches, as well as local radio broadcasts. Others reported providing training in mental health for traditional healers and pastors. Participants reported that campaigns often target adolescents who are at risk of drug abuse. In addition campaigns are targeted at women of maternal age who are at risk of depression and other

disorders related to maternity.

There is some coverage of mental health topics in the national newspapers in Ghana. Between 1992 and 2005 the most popular national newspaper, the Daily Graphic, published 191 articles on mental health. The most commonly reported topics were suicides, drug abuse, charitable donations to psychiatric hospitals and overcrowding, understaffing and poor conditions in the state psychiatric hospitals. In the last two years there has been more coverage of the human rights of the mentally ill, including a review of mental health legislation, and calls for an improvement in psychiatric services.³² Newspaper articles are only accessible to those who read English.

Inter-sectoral collaboration

There are some formal collaborations between the Mental Health Unit and the departments and agencies responsible for primary health care/community health, reproductive health, child and adolescent health, substance abuse, education, criminal justice and social welfare. However there is no collaboration with programmes for HIV/AIDS, child protection, employment, housing and the elderly.

In terms of support for child and adolescent health, no primary and secondary schools have either a part-time or full-time mental health professional. However, it is estimated that between 1-20% of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders in the form of talks and lay counselling.

Mental Health and Poverty

There is an absence of mental health in the development discourse on poverty in Ghana. For instance, several initiatives for the alleviation of poverty do not expressly target people living with mental illness even though they may be classified as among the most vulnerable and excluded in the society. A National Social Protection Strategy was introduced in 2008 to provide social assistance to the 'poor, vulnerable and excluded'. Although it aims to assist the 'extremely poor' and 'severely disabled' it has not yet specifically targeted the mentally ill as needing assistance.³³ This is partly because the mentally ill fall under the Ministry of Health while the policy is implemented by the Ministry of Manpower, Youth and Employment which has oversight over the Department of Social Welfare.

There are very limited social welfare benefits available in Ghana, two of which have been introduced in the last 2 years. The District Poverty Alleviation fund is available for those facing severe economic hardship. Social welfare departments can also make discretionary payments to the destitute, for example meeting their emergency medical costs. Since the passage of the Disability Act in 2006³⁴, the District Assemblies are supposed to dedicate up to 2% of their Common Fund (funds dispersed to local government for development projects) to those with disabilities. In 2008 the government introduced the Livelihood Empowerment Against Poverty (LEAP) programme alongside the Social Protection Strategy to provide direct cash transfers to the extremely poor, with additional amounts for households with a 'severely disabled person'.³³ However whilst people

with mental illness are included within the definition of those living with a disability under the Disability Act, mental illness is not readily recognised by many policy makers and implementers as a cause of disability and in the criteria for inclusion into the LEAP programme the emphasis is on physical disability.

Mental health legislation

The existing legislation for mental health in Ghana is the Mental Health Decree of 1972.²⁷ The 1972 decree has provisions for procedures for involuntary admission, including rights to appeal, accreditation of professionals and facilities, enforcement of judicial issues for people with mental illness, and mechanisms to implement the provisions of mental health legislation.

The review of the 1972 legislation utilising the WHO Checklist on Mental Health Legislation identified several areas which were not adequately addressed in the Mental Health Decree. These included inadequate attention to human rights provisions for service users, including the right to humane treatment; confidentiality and privacy; informed consent; the rights of carers and families of users; competency, capacity, and guardianship issues; involuntary admission; and issues of seclusion and restraint. There is little protection in the legislation of vulnerable groups, including minors and women. There is no provision for financing of mental health care and inadequate promotion of mental health within primary or community-based care. There is also insufficient promotion of access to psychotropic drugs, and no provision for educational activities, vocational training, leisure activities, and the religious and cultural needs of people with mental disorders. There is no provision made for the involvement of users of mental health services, families and carers in mental health policy and legislation development and planning.

The new Mental Health Bill was drafted in 2006 with support from WHO.²⁸ It is currently in the office of the Minister of Health, pending submission to parliament to be enacted into law. The 2006 Mental Health Bill adopts a human rights approach to mental health, in accordance with the UN Charter on Human Rights and international consensus on the health care needs of a person with mental disorder. The Bill aims to prevent discrimination and provide equal opportunities for people with mental disorder. It addresses many of the weaknesses of the current Decree, providing for a mental health authority, a mental health review tribunal, and the protection of the rights of people with mental disorder, including the principle of the least restrictive environment and the right to information and participation. The Bill is endorsed by WHO as reflecting best practice in mental health legislation.³⁵ It promotes de-centralisation and community mental health care and regulates traditional and faith-based healing practices. A missing element of the law, identified by the WHO checklist is that although there is mention of the sources of funding for the mental health authority, there is no stipulation on minimum funding requirements for mental health care.

Discussion

The results of the situation analysis reveal that mental health care in Ghana is comparable to many other low income countries in Africa, which show similar patterns of inadequate

resources which are expended largely on institutional care.^{3,36} The research reveals the continued reliance on the inpatient and outpatient services of the national psychiatric hospitals, despite a policy of de-centralisation and a commitment in principle to community mental health care.

Mental health care in Ghana falls far short of WHO's suggested principles for the organization of services, namely accessibility, comprehensiveness, coordination and continuity of care, effectiveness, equity, and respect for human rights.⁶ WHO suggests that the optimal mix of mental health services may be conceptualized as a pyramid with most, at the base of the pyramid, able to give self care, while a small minority at the top of the pyramid need to use specialised psychiatric services⁶ (see figure 2).

Figure 2: Optimal mix of mental health services (WHO, 2003)



This model argues that greater numbers of people with mental illness should be treated through informal community care and primary health care, than within specialised community mental health and psychiatric services. Such a model aims to ensure that specialised resources are targeted to those most in need, and that everyone who needs treatment for mental disorders has access to the appropriate level of care. Given the limited resources for mental health in Ghana, and the inequitable spread of services, we consider how the different levels of this pyramid could be enacted in Ghana, maximising the resources available at each level.

Self Care

The situation analysis showed that there is a lack of awareness of mental health and illness among many in Ghana and few public education programmes for mental health. There is therefore a need to empower people to give self care through an active public mental health education programme. Topics need to include causes, symptoms, and prevention of mental illness, access to treatment and government programmes on disability and poverty alleviation, and safeguarding patient rights.

Support for families through education and carers' groups would assist families in caring for family members with mental illness. Such programmes have proved successful in India and China^{37,38} and carers' groups have been initiated by Basic Needs in Ghana, but there is a need to scale up such interventions nationally.

Informal Community Care

Informal community care in Ghana is offered through faith and traditional healers. Human rights abuses by these healers have been reported, however they remain very popular. Many Ghanaians approach faith and traditional healers for common mental disorders such as anxiety and mood disorders.³⁹ This is reflected in the low numbers of people with common mental disorders who utilise mental health services.

There have been few attempts to develop and supervise the services of traditional and faith healers in Ghana.^{18,40} In order to reduce the abuse of people with mental illness within informal treatment facilities, it is recommended that a mental health authority and tribunal is established as stipulated in the new Mental Health Bill to regulate the practices of traditional and faith healers. Closer collaboration between faith and traditional healers and orthodox psychiatric care could help to protect the human rights of those with mental illness and ensure that those who would benefit from psychiatric treatment are referred to appropriate services. Initiatives by Basic Needs to work with traditional healers in Northern Ghana have suggested the potential for successful collaboration.¹⁸ There is a need to provide training for traditional and faith healers on mental health, psychiatric treatment, ethics and human rights. Local government at the district level (District Assemblies) could help by providing some funding to upgrade the facilities at faith and traditional healers to further improve care given to patients.⁴¹

In addition there is a large number of Community Based Surveillance Volunteers (CBSVs) and Traditional Birth Attendants (TBAs) who are posted to mainly rural communities. WHO calls them 'local experts'⁶, who as frontline workers can direct community members to appropriate healthcare. The training of such volunteers in mental health could enable them to extend their support services and make appropriate referrals of people with mental illness. There is however a need to consider issues of remuneration for such volunteers in order to ensure they are motivated and committed to complete their work effectively.

Mental Health Services through Primary Health Care

The integration of mental health into primary health care services would ensure that those with mild and moderate mental disorders are able to access care through primary health care facilities, with referral to specialist services only for those with severe symptoms. This would require training primary health care workers in the detection and treatment of mental disorders and providing regular supervision by mental health professionals. There should be reliable access to psychotropic medication at the district and sub-district level and effective systems of referral and back-referral between primary care and specialised mental health services. Mental health should also be included within the wider public health care initiatives of district health services such as maternal, child, and adolescent health.

There is also a need to strengthen the mental health information system in primary care to enable more

efficient planning and resource allocation for mental health. In addition, multi-sectoral district mental health advisory committees should be established to advocate for mental health within relevant sectors such as education, the police and judiciary, social services, and faith and traditional healers.

Community Mental Health and Psychiatric Services in General Hospitals

As the results show, only 69 of the 138 districts have community psychiatric nurses. Even where a CPN service is provided, there are often only one or two nurses for the district, and they have no access to transport. Therefore the service is severely limited in its ability to reach those in need. The number of CPNs is diminishing as many are nearing retirement and there is no programme for their replacement. In addition to training and posting more CPNs, the proposed training of new cadres of community mental health workers (see <http://thekintampoproject.squarespace.com>) would enable the expansion of community mental health care. Strengthening the provision of community mental health services, ensuring an adequate and reliable supply of psychotropic drugs, as well as the provision of transport for community health workers, would improve access to treatment within the community and help prevent the need for hospital admission for many. The Ministry of Health should also consider the hiring of allied mental health professionals such as psychologists, for districts to provide psychosocial interventions.

Access to treatment at the community level is particularly important in Ghana since many communities are far from inpatient psychiatric services which are located in only half of the regional capitals. Many patients bypass these and are admitted to the large psychiatric hospitals in the south, meaning treatment is even further from the person's home. This has implications for the re-integration of the person into his or her community following discharge, particularly given the frequently lengthy admissions and the stigma associated with the psychiatric hospitals.

Psychiatric units should be opened in general hospitals in the remaining regions, and systems of referral and back-referral with primary care strengthened so that use of the regional units is maximised. More beds should be provided at the regional psychiatric units in order to aid the process of de-institutionalisation and provision of care nearer home.

Specialist Services

De-institutionalisation is required to reduce the numbers of long-stay patients in the psychiatric hospitals so as to offer humane, high quality care for those most in need. There is also a need for more diversity within specialised services. At present inpatient care is largely medicinal with little attention to psychosocial interventions. Half-way houses and vocational rehabilitation could help with the process of de-institutionalisation, particularly for those long-stay patients who are estranged from their families, and are in need of a graded reintroduction to life within the community.

Information systems

The completion of the WHO-AIMS, which relies on data collection by government, private and voluntary services, revealed some of the weaknesses of the health information system in Ghana, particularly in respect of mental health, in which much data is not gathered at all, or is inconsistent or unreliable. This highlights the need for the introduction of a standardised and comprehensive mental health information system in order to provide the necessary evidence for scaling up mental health services in Ghana.

Crucial to the success of the new Mental Health Bill, when adopted will be the collection of accurate routine data which will inform relevant institutions about the use of services and the protection of the rights of users. From a legal point of view, therefore, strengthening of the mental health information system is an urgent necessity.

Funding

In low-income countries cost-effective health care is a major priority. A number of studies on the cost-effectiveness of community care for mental disorders in low-income countries have been published.^{11,42-44} It has been calculated that scaling up mental health care in low-income countries would cost around \$2-3 per person per year.⁴³ This is based on a core package for the treatment of schizophrenia, bipolar affective disorder, depression and hazardous alcohol use in which the majority of people with these conditions are treated within district level mental health services and primary care.

Plans for funding improvements in mental health services may need to be outlined more clearly in the Mental Health Bill. Funding sources stated in the Bill are subject to the discretion of budget officers, and ministers of health and finance. Given the low priority of mental health this raises the risk that mental health may be overlooked.⁵⁹ De-institutionalisation should release some funding for community mental health care, however, as WHO points out, there may be a need for significant investment in such aspects as training, personnel, and transport, particularly at the outset, to establish mental health within primary care.⁶

Conclusion

This paper provides a comprehensive review of mental health policy and service provision in Ghana, and charts a way forward for the development of mental health care. Crucial to this is the enactment of the current Mental Health Bill which has been subject to long delays. The new administration in Ghana has promised to pass the Bill into law. Together with a commitment to its implementation and the allocation of appropriate resources, the passing of the Mental Health Bill would mark a significant step forward in the transformation of mental health care in Ghana.

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