

Scaling up community-based services and improving quality of care in the state psychiatric hospitals: the way forward for Ghana

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⁵**The Mental Health and Poverty Project (MHaPP)** is a Research Programme Consortium (RPC) funded by the UK Department for International Development (DfID)(RPC HD6 2005-2010) for the benefit of developing countries. The views expressed are not necessarily those of DfID. RPC members include Alan J. Flisher (Director) and Crick Lund (Co-ordinator) (University of Cape Town, Republic of South Africa (RSA)); Therese Agossou, Natalie Drew, Edwige Faydi and Michelle Funk (World Health Organization); Arvin Bhana (Human Sciences Research Council, RSA); Victor Doku (Kintampo Health Research Centre, Ghana); Andrew Green and Mayeh Omar (University of Leeds, UK); Fred Kigozi (Butabika Hospital, Uganda); Martin Knapp (University of London, UK); John Mayeya (Ministry of Health, Zambia); Eva N Mulutsi (Department of Health, RSA); Sheila Zaramba Ndyabangi (Ministry of Health, Uganda); Angela Ofori-Atta (University of Ghana); Akwasi Osei (Ghana Health Service); and Inge Petersen (University of KwaZulu-Natal, RSA).

Abstract

Objective: This paper aims to explore the options available for developing community-based care and improving the quality of care in psychiatric hospitals in Ghana. **Method:** Semi-structured interviews (SSIs) and focus group discussions (FGDs) were conducted with a cross-section of stakeholders including health professionals, researchers, policy makers, politicians, users and carers. The SSIs and FGDs were recorded digitally and transcribed verbatim. Apriori and emergent themes were coded and analysed with NVivo version 7.0, using a framework analysis. **Results:** Psychiatric hospitals in Ghana have a mean bed occupancy rate of 155%. Most respondents were of the view that the state psychiatric hospitals were very congested, substantially compromising quality of care. They also noted that the community psychiatric system was lacking human and material resources. Suggestions for addressing these difficulties included committing adequate resources to community psychiatric services, using psychiatric hospitals only as referral facilities, relapse prevention programmes, strengthening psychosocial services, adopting more precise diagnoses and the development of a policy on long-stay patients. **Conclusion:** There is an urgent need to build a credible system of community-based care and improve the quality of care in psychiatric hospitals in Ghana.

Key words: Psychiatric hospital; Community psychiatry; Psychosocial services; Low and middle-income countries; Ghana

Received: 07-11-2008

Accepted: 07-07-2009

Introduction

The treatment of the mentally ill from ancient times to the present reflects prevailing perceptions of mental illness. Initially people with mental disorders were beaten, burnt at the stake or hanged. One example is that of the "Salem witches"

trial in Massachusetts in 1692 in which 19 people (14 women and five men) accused of witchcraft were found guilty and hanged.¹ Later, people with mental disorders were "warehoused" in "lunatic asylums", without any treatment or care, as the emphasis was on protecting the general population from the perceived violence of the mentally ill.

With the discovery of chlorpromazine for the treatment of schizophrenia in 1952 and other psychotic mental health conditions, psychiatric hospitals began to replace the lunatic asylums and some level of treatment and care was provided.

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However, from the early 1960s, the psychiatric hospitals started experiencing their own problems which included congested wards, admission of patients without precise diagnosis, long admission periods and human rights abuses. Other problems included the negative consequences of institutionalisation, such as the loss of social skills and the induced lack of initiative of institutionalised patients.²⁻⁴

The use of alternatives of care for the mentally ill was consequently developed to remedy the concerns of institutionalisation in psychiatric hospitals.³ One model that has been widely used is to maintain the psychiatric hospitals strictly as referral facilities for people whose conditions warrant specialist institutionalised care, while the majority of service users should access psychiatric services in their communities. This is only feasible of course, if the infrastructure for community facilities is in place, and appropriate human resources are located in the communities. Some stakeholders have even made radical suggestions that the psychiatric hospitals are not necessary, and that patients who need long term care should be accommodated in community residential facilities.^{5,6}

In practice, community care practices involve the development of a wide range of services within local settings.⁶ This process attempts to ensure that some of the protective functions of the psychiatric hospitals are fully provided in the community, and their negative aspects are not perpetuated.³ Care in the community, as an approach, has clear advantages that reflect best practice in the provision of treatment, rehabilitation and general care of psychiatric patients.^{7,8}

The decentralisation of care in this manner would mean that people with mental health problems would have services which are close to home^{6,8}, including general hospital care for acute admissions⁹, and some level of long-term residential facilities in the community. It should also include the use of a wide range of services which address the needs of the users¹⁰ and services which are coordinated between mental health professionals and community agencies.^{11,12}

Several international agencies, such as the World Health Organization (WHO), and empirical experiences from many countries have stressed that the decentralization of care without the establishment of human, financial and infrastructural resources for the community-based services is a peril both to the communities and the patients.^{2,4} The strategy of choice is to put community resources in place first, and then begin a gradual decentralisation of the hospitals in a coordinated manner, accelerating at the pace at which the communities are able to take up the patients.^{2,3,6}

Service users and carers would then notice the availability of psychiatric services within their communities and start using them. Fewer people would then be travelling to the psychiatric hospitals for care, and as a result, the psychiatric hospitals would be decongested as a matter of course.

In spite of the known advantages of credible and cost-effective alternatives to the institutionalised treatment in the psychiatric hospitals, the transition to these alternatives has not been smooth in most low and middle-income countries (LAMICs). This is partly due to the fact that resource timing, distribution and inflexibility tend to thwart the gains of the system.¹³ Also there are instances of government reluctance to build community structures and resources after much investment has gone into the building of large psychiatric

hospitals. This is in spite of research evidence that suggests that in the medium and long term, the community psychiatric system is more cost effective than institutionalisation in the psychiatric hospitals.¹⁴

There are examples of initiatives with varying degrees of success in LAMICs, where attempts were made to decentralise psychiatric hospitals. Brazil had an effective shift from the psychiatric institutionalisation to the community service system as a result of operational edicts enacted by the Ministry of Health.¹⁵ Another attempt was in South Africa, where the new Mental Health Care Act promulgated in 2004 provided the impetus to develop a community-based system with emphasis on rehabilitation backed by comprehensive protocols at all the levels of care. However, the South African initiative has to date achieved limited success, as insufficient resources have been allocated to staffing and structural changes required to implement the Act. Resource allocations continue to be inequitable, and only a quarter of mental health professionals are employed in community mental health, with the majority still practicing in institutional settings in urban areas.^{16,17}

Elsewhere in low-income countries in Africa, there have been some attempts to study national mental health system profiles, and to identify the main obstacles hindering best practice and strategies to overcome them. For example, Uganda has made attempts to reduce the obstacles militating against the delivery of mental health services¹⁸, and Zambia has identified the problem of very low psychosocial support which the country is aiming to improve.¹⁹

The international research literature contains many credible alternatives to the use of large state psychiatric hospitals for care delivery all over the world. However, in the case of Ghana there has been little research conducted on feasible alternatives to psychiatric hospital care.²⁰ This paper aims to explore the views of stakeholders about the credible ways of building community-based services and improving the quality of care in state psychiatric hospitals in Ghana. This research is necessary to inform Ghanaian policy on the development of mental health care, in the face of a substantial burden of disorders.

Methodology

We collected both quantitative and qualitative data in a cross-sectional survey. Quantitative data were collected using the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) version 2.2. The WHO-AIMS is a questionnaire designed to assess national mental health systems.²¹

Qualitative data consisted of semi-structure interviews (SSIs) and focus group discussions (FGDs). These were conducted with 48 respondents at the district, provincial and national levels. The SSIs and FGDs were conducted by two graduate research officers with backgrounds in psychology.

The respondents for the qualitative data were purposively sampled, based on their status as being able to provide information on behalf of their institutions, or based on their expertise. They included mental health professionals, policy makers, academics, administrators, health researchers, the media, religious leaders, traditional and faith healers as well as users of psychiatric services and their carers.

The interviews were digitally recorded (with permission from the respondents) and transcribed verbatim. Ten percent of the interviews were randomly selected and sent to the respondents for validation, and all of them agreed that the

transcriptions were a true reflection of what they said during the interviews. Three other respondents who requested seeing the transcription of their interviews were provided copies to read, and they confirmed that the transcriptions were a true reflection of what they said.

A framework analysis²² was used, where the researchers first familiarised themselves with the transcriptions and the codes. The codes were then entered into NVivo qualitative data analysis software, charted and mapped. The final analysis was done, paying particular attention to concordant as well as divergent views. To ensure that coding was rigorously done to capture all the important information, ten of the transcriptions (21%) were randomly sampled and subjected to multiple coding, that is, they were simultaneously coded by the research officer and research assistant. Multiple codings produced concordant rates consistently higher than 90%.

Scientific and ethical clearance was given by the Scientific Review Committee and the Institutional Ethics Board respectively, of the Kintampo Health Research Centre. Ethical clearance was also given by the National Ethics Board of the Ministry of Health, Ghana.

Results

Current state of psychiatric hospitals in Ghana

The three psychiatric hospitals with a cumulative capacity of 1,500 beds have a total population of about 2,100 in-patients at any point in time. The Accra Psychiatric hospital which is the largest in terms of patient intake has a capacity for 500 in-patients, but accommodates an average in-patient population of 1,100. That makes it the most congested psychiatric hospital in the country, with a bed occupancy rate of 220%. The other two psychiatric facilities with a total capacity of 850 beds accommodate the other 1000 in-patients, (an occupancy rate of 129%). The three state psychiatric hospitals therefore have a mean bed occupancy rate of 155%. What this means practically is that when a patient is admitted to the Accra Psychiatric Hospital at any point in time, the chance of that patient sleeping on the floor is higher than the chance of getting a bed to sleep on.

The number of patients seen at the outpatient departments of the three hospitals is about 75,000 which indicates a heavy clinical workload. The Accra Psychiatric Hospital sees 62.5% of this outpatient attendance.

Strategies for improving mental health care

Respondents in the interviews and focus group discussions gave many suggestions on how to improve current mental health service provision. The major strategies are discussed below. Some of the suggestions are interpreted with relevant data from the WHO-AIMS survey.

1. Strengthening of community psychiatric services

There are only 115 community psychiatric nurses in Ghana, servicing the population of 22 million people. This represents 0.52 psychiatric nurses per 100,000 population. There were concerns from many of the respondents, especially the mental health professionals, about the relative neglect of the community psychiatric system. It was stressed that the improvement of community psychiatry should be one of the cardinal ways of reducing the clinical load in the psychiatric hospitals.

According to one respondent,

"If the community mental health is well catered for there would be less problems for the clinical side, I mean the psychiatric hospitals". (A coordinator, Community Psychiatric Nursing)

Another concern raised was that of ageing community psychiatric nurses (CPNs) and the lack of potential replacements, due to lack of interest in the community care system. Many community psychiatric nurses and other professionals are not attracted to serve in community settings.

"... We have community psychiatric nurses in the community, those in the community, they are ageing because of shortage of staff. Very soon they will phase out. Who are to replace these people?" (Senior nurse, Accra psychiatric hospital)

Another respondent enumerated the challenges faced by CPNs, which make the community psychiatric service unattractive:

"What I will say is that the area, that is the community mental health area is an area that they have to take very serious otherwise just two years to come the unit may not be in existence and if the unit is no more in existence it's there that we will see it's usefulness and by that time it may be too late. Why should you be doing community work without a transport, walking for so many years from 1975 up to this time? No incentives..." (A CPN Coordinator)

Many of the respondents suggested a cautious rather than a hurried move to strengthening community psychiatric services. The process should be gradual and holistic, and should include not only the training of more professionals for the community mental health system but also the establishment of credible strategies to reduce the stigma of mental illness, as the communities get prepared psychologically to accommodate the mentally ill. This theme was very conspicuous especially among the mental health professionals and the policy makers throughout the interviews. One of the policy makers, under whose administration the psychiatric hospitals fall, explained:

"We want to actually look at mental health not only in what I call 'isolated institutions'. We want to enter into the community and then what I will call 'de-boardinise' the patients from the psychiatric hospitals, settle them in their communities so that we can actually build the capacity of the care givers to take care of them in the community. Then we are also looking at the very first thing of trying to reduce the stigma..." (Policy maker, Ministry of Health)

Interviewer: "Yes that's interesting, de-boardinising mental health care, but the psychiatric hospitals seem to be growing in terms of number of inmates despite..."

Respondent: "We have not reached there yet. We are saying we are making efforts towards that. You see making efforts towards that would mean putting certain structures and systems in the community, building the capacity of people who can take care of them in the community, making them to be accepted in the community".

When questioned about the availability of community psychiatric nurses, one respondent said:

"...No, even in the district that we dealt, I think it was Bekwai that had one. Sekyere West which was Mampong didn't have a psychiatric nurse. Yes so we knew that there were not many of the psychiatric nurses, that is why we prefer that there will be some kind of community involvement in this. So that at least if they can refer, if there is no psychiatric nurse around I mean they can refer" Policy maker, Ministry of Health

2. Psychiatric hospitals as referral facilities

One of the strategies identified by respondents was for the psychiatric hospitals to be used as referral facilities. This means that in practice the psychiatric hospitals should not be used as the first points of treatment when people develop mental disorders. They should only be used when the lower level facilities are not able to deal with a particular condition.

One senior mental health professional explained:

"So this is what we are aiming at, that the patients... those who come here should come here as referrals, not coming to us straight. So this is one of our priorities". Senior mental health nurse, Accra Psychiatric hospital

Even though most respondents were of the view that the decentralisation process of the psychiatric hospitals should be a gradual process, there were some radical views, such as this one:

"...at this stage they have to think about de-emphasising institutional care as we have been talking about. We need to improve on the community care aspect and dismantle some of the large hospitals that we are unable to manage properly. We thought the Accra psychiatric hospital will not exist after the year 2000, but it is still there... What it serves is not really giving mental health the desired recognition because the conditions are very poor..." Retired Chief Psychiatrist

3. Relapse prevention

According to most respondents, relapse prevention is at the heart of decongestion of psychiatric hospitals in Ghana. The data collected from WHO AIMS indicates that between 75% and 90% of the psychiatric patients seen at the Accra Psychiatric Hospital are patients who have been treated and

then relapsed, and have come for readmission. Similar findings pertain to the other two state psychiatric hospitals. This means that if comprehensive strategies were put in place to prevent relapse, a substantial number of treated people would not come for readmission to the hospitals. This would contribute to the reduction in the clinical workload in the psychiatric hospitals.

Many of the respondents indicated that relapse prevention can be achieved by several means, including the early recognition of symptoms of relapse and the establishment of therapeutic communities. The latter requires that when patients are discharged they will return to a community environment that is accommodating, sympathetic and ready to accept and re-integrate them. According to the respondents, these communities should be therapeutic, where sympathy is the watchword and stigma and discrimination are reduced to the minimum.

One respondent gave a graphic description of the grim situation of relapse in psychiatry that has become known as the revolving door phenomenon:

"...so when you look at our statistics, we looked after about 46,000 patients (in the Accra Psychiatric Hospital) for the whole of last year and out of this 46,000 patients, about 4,300 were new cases. The rest were all old cases so that means they come, go, come and go. That's all our psychiatric patients are doing. So in psychiatry now it's patients just coming in, and then going out and then coming back again". Senior pharmacist at the Mental Health Unit, Ministry of Health

This revolving door phenomenon occurs not only because of the recurrent nature of some mental disorders, but mainly due to the poorly developed community psychiatric system.

WHO AIMS data revealed that not all the patients who "come and go" are in-patients. Most are out-patients who require visits at regular intervals for review and medication monitoring. This situation underlines the importance of local clinics within the community psychiatric service system. These clinics are more accessible and less stigmatising than visiting the psychiatric hospital for outpatient care.

4. Strengthening psychosocial services

The mental health system in Ghana relies almost exclusively on medication, with very little importance attached to psychosocial services. There is only one full-time clinical psychologist in one of the state psychiatric hospitals in Ghana (Ankaful Hospital), and he has worked for more than two years without a regular salary, as clinical psychologists have no placement within the human resource structure of the Ghana Health Service.

The Social Welfare Department is severely under-resourced, and does not conduct follow-up and needs assessment services for discharged patients. The occupational therapy unit in the Accra Psychiatric Hospital has no occupational therapist. Only a few artisans, made up of carpenters, seamstresses and shoe makers operate there, in a relatively large, but dilapidated structure.

Many respondents indicated that with very little psychosocial support, long-stay patients who have lost basic occupational skills and are discharged to their communities, become a burden to their caregivers and their communities. They therefore face much criticism and neglect, which contributes to their relapse.

One respondent lamented the lack of resources and the motivation of workers at the social welfare unit and the occupational therapy unit, as follows:

"In fact, in terms of resources I will say that there are no meaningful resources, so it makes the work really very challenging. Even as at now, I don't even have paper to write on. Most often, I have to use my own meagre salary, and if I should show you my pay slip you will marvel". Social welfare officer, Accra Psychiatric hospital

She also had this to say about the occupational therapy department:

"And even there, you will see them hanging around and when you ask aren't you going? They will say 'oh they are not doing anything'. There too I believe that the resources are not there". Social welfare officer, Accra Psychiatric hospital

Another respondent described the paucity of psychosocial services in the psychiatric hospitals as follows:

"Our social welfare departments have been reduced to repatriating departments... they just go and leave the patient with the relatives and that is all. Now the whole system has fizzled down to our use of the institution and drugs, stabilising the patients, sending the patients home and then we sit down and wait for the patients to come back". Senior social worker, Accra Psychiatric Hospital.

5. Precise diagnosis

The limited personnel, the clinical workload, lack of a well defined information system, the absence of a uniform diagnostic system throughout the mental health services and the lack of equipment means that the diagnosis of patients is reduced to a short clinical history that is narrated by the patient or the caregiver and a mental state examination. Alternatively, it is based on the observation of patients on admission, or on the wards.

This was cited by some respondents as contributing to congestion in two ways. Firstly, the lack of a more thorough diagnosis means that many people who otherwise should not have been admitted would find themselves being admitted, even if admission does not confer any benefits to them. Secondly, some of the patients who are admitted but do not have an adequate examination and consequently do not have a precise diagnosis may end up staying longer in the psychiatric hospital as their treatment would, to some extent, be on "experimental basis", and they would take longer to recover.

One respondent said:

"Anybody who comes here with a seemingly mental illness is a mental patient. That is the attitude. So long as you have been carried here, you are a mental patient... if you try to make the experiment of coming in here with a seemingly mental illness you would be admitted and diagnosed".

Interviewer: "And then for a long time you would be here?"

Respondent: "You would be here; you would 'become' a mental patient"

Interviewer: "Nobody can determine that you are not a mental patient?"

Respondent: "Because we are not doing any chemical analyses, we are relying on history, so once your history says that you have a mental illness you are a mental patient, do you get me?"

Senior mental health professional, Accra Psychiatric Hospital

6. Policy on long-stay patients

Most of the respondents were of the view that in a country with limited resources and low budget allocation for mental health, it is undesirable to keep psychiatric patients on admission beyond the optimal periods that they would benefit from hospital care. Apart from developing the negative habits of prolonged "institutionalisation" which include dependency, these patients are an unnecessary drain on the meagre resources of the psychiatric hospitals. It was found that some of the long-stay patients have been in the psychiatric facilities for periods ranging from 10 to 20 years. Some of them have had multiple admissions, and finally decided to stay "permanently" in the psychiatric facilities, mainly due to the hostile atmosphere in their communities.

"There are some of the patients, even they have gone in, out, in, out so much that they prefer to stay permanently in the hospital. We've got patients who have been in the hospital for over 20 years, occupying a single bed... They are fed and they keep on staying in the ward. That is what is happening. The moment you tell them you are discharging them, they relapse." Senior mental health professional, Mental Health Unit

Another source of congestion that is partly related to long-stay patients has to do with people brought to the psychiatric hospitals by the police or the courts for assessment. Respondents stated that many of these patients are left at the hospital long after their assessments have been completed. This adds to the unnecessary resource drain on the psychiatric hospitals.

Respondents point out that the phenomenon of long-stay patients has been a thorny issue in the administration of psychiatric hospitals and that this had been documented in local media. For example, the Chief Psychiatrist of Ghana publicly appealed to the Ghana Police Service and the Commission on Human Rights and Administrative Justice to collect more than 500 suspects brought to the hospital for

forensic assessment, and who have remained in the hospital for prolonged periods after the assessments were completed, largely because the police service had not collected them (Daily Graphic of Saturday, February 9th 2008). He said situations like this add to the congestion and strain on the hospital facilities and budget.

Discussion

The findings of this study highlight the practical problems facing the effective running of the psychiatric hospitals in Ghana, particularly congestion and heavy clinical caseloads. These problems have profound negative consequences for quality of care, and human rights of people with mental disorders. The study also documents the views of a range of mental health stakeholders in Ghana regarding the feasible options available to improve the current state of psychiatric services.

Six major strategies were identified by respondents. The main proposal is the strengthening of the community psychiatric service system, particularly through the commitment of adequate financial and human resources. Corroborative research evidence has shown that community care has a better outcome for patient recovery⁶, and is also more cost effective¹⁴, given the existence of support structures. It also has the potential for promoting human rights of users in a manner not possible within institutional care.^{6,23}

All of the remaining strategies pertain to improving the quality of care in existing psychiatric hospitals in Ghana. These were the use of the psychiatric hospitals as referral facilities, concerted efforts at relapse prevention, the strengthening of psychosocial services, the establishment of precise diagnostic practices through a combined history-taking and laboratory screening where indicated, and the establishment of a policy on long-stay patients whose continued stay as in-patients is not medically indicated.

Respondents pointed out that these strategies reinforce each other positively in several ways. For example, when psychosocial services are strengthened, they do not only ensure that patients get well more quickly to reduce congestion, but these services also reduce relapse and readmission rates. In the same way, when more patients are managed by the community mental health system, it automatically reduces the number of patients visiting the psychiatric hospitals.²³

The Brazilian experience suggests that there could be substantial reforms in the mental health system when there is sufficient commitment from mental health professionals and policy makers. With some commitment, CPNs could accept placement to the communities to work in spite of the challenges. It has also been shown that after initial resource allocation to the community psychiatric system, subsequent savings from the budget of the psychiatric hospitals as a result of reduced intake could be channeled into the community service delivery, to buttress the subsequent budgetary allocations that the system receives.^{5,15} However, it should be noted that while community services are being established there may be initial double running costs, as psychiatric hospitals are maintained and community services developed, as noted by some authors and the WHO.^{5,24,25}

The state psychiatric hospitals have not been symbols of best practice in Ghana and many other LAMICs because they

are congested, unsanitary and carry the vestiges of stigma and discrimination. Bold attempts need to be made to strengthen community-based resources and make communities sympathetic and therapeutic enough to accept most of the cases that would have found their way into the psychiatric hospitals. The important point to note from respondents' recommendations is that the establishment of credible community-based services were not seen as an alternative to psychiatric hospitals, but that their development should be accompanied by changing the role of psychiatric hospitals and improving the quality of care in these institutions. The range of strategies offered suggests that both elements are necessary.

It should also be noted that despite the importance of comprehensive laws and policy documents, these are not enough to achieve the quality of mental health care desired if there is no political and professional will. This is illustrated in South Africa, where legislation sets out the strategies for an overhaul of the psychiatric service system, but the lack of equitably distribute resources (including staffing) has hampered the implementation of these strategies.¹⁶

Conclusion

Best practice and the efficient use of resources requires that Ghana should build a credible community psychiatric system and improve the quality of care in psychiatric hospitals. These efforts have to be coordinated to ensure that the "spill-over" of psychiatric patients into the communities does not occur at a time when the communities are not yet equipped to absorb and cater for their clinical and psychosocial needs.^{7,6}

One anticipated challenge is the development of a comprehensive cadre of mental health professionals and psychosocial service providers in the communities, as most of these professionals have hitherto been working in the cities where the psychiatric hospitals are located. It would therefore take a great deal of motivation and commitment to get most of these professionals into the communities, most of which are rural.

Research into best practice for the mentally ill have shown that well resourced community-based services are the treatment of choice in a wide range of international settings.³ Concerted efforts should therefore be made to develop community-based care and improve the quality of psychiatric hospitals, including commitment to the provision of financial resources, infrastructure and staffing.

Acknowledgements

This research was funded by the UK Department for International Development (DfID RPC HD6 2005- 2010) for the benefit of developing countries. The views expressed in this paper are not necessarily those of DfID. We would like to acknowledge the Ministry of Health, Ghana, for giving permission for this study, and the respondents for their valuable contributions.

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