Phase 1. Country Report

A situation analysis of mental health policy development and implementation in Ghana

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Acknowledgements

Key to Acronyms Used

CBSV   Community Based Surveillance Volunteer

CHARJ   Commission for Human Rights and Administrative Justice

CHPS   Community Health Planning and Services

CPN   Community Psychiatric Nurse

DHMT   District Health Management Team

GES   Ghana Education Service

GHS   Ghana Health Service

GPRS   Growth and Poverty Reduction Strategy/Ghana Poverty Reduction Strategy

KHRC   Kintampo Health Research Centre

MDG   Millennium Development Goals

MOH   Ministry of Health

WAJU   Women and Juvenile Unit

WHO   World Health Organization

Executive Summary

Introduction:

There is growing recognition in many countries that mental health is a crucial public health and development issue. There is also emerging evidence that a range of clinical, social and economic interventions can have a positive benefit for the mental health of communities. Yet mental health is not given the priority it deserves. The aim of this study is to examine mental health policy development and implementation in Ghana, with a view to identifying the key barriers to mental health policy development and implementation, and steps that can be taken to strengthen the mental health system in the country. This study forms part of a broader international mental health research consortium based in Ghana, South Africa, Uganda and Zambia, which 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.

Methods:

The study makes use of quantitative and qualitative methodologies. Quantitative methods were employed to assess current mental health resources (such as budgets, beds, staff) and service utilisation. Qualitative methods were employed to provide an understanding of the processes, underlying issues and interactions between key stakeholders in mental health policy development and implementation.

Quantitative instruments included:
- o World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2
- o The WHO Mental Health Policy and Plan Checklist
- o The WHO Mental Health Legislation Checklist

Qualitative instruments included:
- o Semi-structured interviews
- o Focus group discussions

Interviews and focus group discussions were conducted at the national, regional and district level.

Data for the WHO-AIMS was collected for the 2005 index year. Quantitative and qualitative data collection took place between 14th September 2006 and 30th August 2007.

Findings:

The findings of the research identified a number of challenges facing the provision of mental health care in Ghana.

Policy and legislation

Mental health policy in Ghana was formulated in 1994 and revised in 2000. Whilst the policy emphasises the decentralisation of mental health services and the development of community mental health care, there has been limited progress towards implementing the policy. Barriers to mental health policy implementation identified by participants included the stigma towards mental health, a lack of human and material resources, little communication of the policy, and no training for those responsible for its implementation. There is no consultation with users of mental health services, their families, and health professionals at the district level in the formulation of mental health policy. In addition, there is limited intersectoral collaboration with other agencies such as the police and education service, in the development of mental health policy. Importantly, there is little reliable data gathering and dissemination of research to inform mental health policy and planning. Despite widely acknowledged links between mental health and poverty, mental health is not addressed within national policy on development and poverty alleviation.

Current mental health legislation does not reflect best practice in mental health, such as establishing community-based mental health services and protecting the human rights of persons with mental health problems. A new mental health bill has been drafted drawing on an extensive consultation process with stakeholders and WHO. The bill seeks to protect and promote the rights of the mentally ill, however it has not yet been ratified and there remain challenges to ensure that the bill is implemented.

Mental health services

Some moves towards de-centralization of mental health care have begun with the opening of psychiatric units in the regional hospitals and the establishment of community psychiatric nursing services within 68 districts. Mental health has been integrated into all the Regional Health Management Teams and into those District Health Management Teams where community psychiatric nurses are in post. Initiatives through NGOs and other agencies to enhance the community detection of mental illness and provide treatment have met with some success and draw on the availability of public health workers at the sub-district level.

However progress towards the decentralization of mental health care in Ghana has been limited. Despite the opening of psychiatric units in some of the regional hospitals, specialised inpatient care remains largely concentrated in the three psychiatric hospitals in the south of the country. The population of the poorest parts of the country is therefore reached the least by mental health services.

Community-based mental health services are provided in only about half of the districts in the country. There are insufficient numbers of community psychiatric nurses and other mental health professionals and little integration of mental health within primary care. Poor communication between psychiatric services and primary care is leading to a lack of effective procedures for follow-up of discharged patients within the community.

Treatment for mental health is largely biomedically based and curative. There are very limited numbers of psychosocial professionals in mental health care and a lack of rehabilitation and psychosocial treatment for mental health. There are few programmes for mental health promotion and the prevention of mental illness.

In addition, services are primarily focused on treatment for severe mental disorders such as psychosis and schizophrenia. There is little focus on treatment for common mental disorders such as depression at the community level.

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Human resources

Despite an increase in the number of training places available for psychiatric nurses and other health professionals such as medical assistants, there remains a lack of human resources within mental health services, including inpatient hospitals and community services. This presents challenges for effective service delivery. It is difficult to attract health professionals into psychiatry due to stigma, low priority of mental health, and fears of violence.

There are very few specialists in psychosocial interventions which impedes the ability of mental health services to provide comprehensive multi-disciplinary care. In addition to psychiatrists and psychiatric nurses, there is a need for clinical psychologists, psychiatric social workers and occupational therapists.

Furthermore, there is little opportunity for continuous professional development for mental health professionals. Other sectors who have contact with those with mental health problems, such as teachers and police, lack vital knowledge on the management of mental health problems within the communities they serve.

Human rights

Traditional and faith healers in the communities are well-placed to address some of the unmet needs of the mentally ill. However there are serious concerns about the abuse of the human rights of some of those who attend their facilities, for example the chaining of patients and enforced fasting.

At present there is no regulatory body for institutions providing care for the mentally ill. Therefore there is no regulation of the practices of traditional and faith healers in the treatment of those with mental illness, nor systematic monitoring of human rights within psychiatric institutions. Poor quality of care and human rights abuses in both government facilities and traditional and faith healing facilities remain officially unchecked, and few attempts are made to protect the rights of those with mental illness.

Stigma

There is significant stigma towards those with mental health problems in Ghana and this extends from the mentally ill to their carers and often to mental health

professionals. People with mental illness encounter stigmatization and discrimination at the institutional, social and family level. In addition, there is stigmatization of the field of mental health itself among health professionals.

Stigma can be a hurdle to the health-seeking behaviour of people with mental health problems and has also affected the recruitment of health professionals and the funding priorities of the health service. It also leads to direct discrimination against those with mental illness in terms of employment, social inclusion and equal opportunities.

Funding

Nationally, mental health remains a low priority in the context of competition for limited resources and a significant disease burden. This is reflected in the insufficient budget allocated for mental health. What is available is mostly dedicated to the psychiatric hospitals.

Mental illness is not currently covered by health insurance which may impede access to treatment for the most impoverished. This means that patients have to bear the cost of treatment when they are treated outside of mental health services or if psychotropic drugs are unavailable within public health services.

Increased demand on mental health services will lead to the need for more readily available psychotropic medication. The cost of providing optimal treatment with new psychiatric drugs may be prohibitive, therefore decisions regarding the best use of limited resources to achieve maximum clinical effectiveness will need to be made.

Rising rates of drug abuse, particularly cannabis, with resulting mental health problems, may put a further strain on existing resources.

Opportunities

At present in Ghana there are a number of encouraging opportunities for the improvement of mental health care:

- o There is widespread acknowledgement at the macro level of the need for de-centralization of mental health service provision and the development

of community-based services, indicating that there would be support from policy makers for further implementation.

o The new mental health bill draws on extensive consultation at all levels of society, including users of mental health services, and which is consistent with WHO best practice guidelines. If passed, the law would signal a new standard for mental health care in Ghana and provide a mandate for improved services.

o There has been considerable collaboration and support for mental health in recent years from international agencies such as the Royal Netherlands Embassy and the World Health Organization. There has also been a growth in the number of both international and local NGOs in the field of mental health.

o Large numbers of traditional and faith healers offer treatment for mental illness at the community level and are well-placed to provide psychosocial and spiritual support. Some have indicated their willingness to collaborate with biomedical services. Additional and regular training would significantly enhance the quality of service provided and allow the government to regulate and monitor the sector.

o There has been renewed impetus to further the cause of mental health in Ghana through research and advocacy. There is increasing research in mental health in Ghana which could raise the profile of mental health and provide an evidence base for further service development.

o Public concern regarding rising rates of drug abuse has drawn increased attention to mental health issues.

Recommendations:

Some suggested steps to be taken to strengthen the mental health system are:

o Pass the new mental health bill, and provide the necessary resources and training for its implementation.

o Promote mental health in the development agenda to address the links between poverty and mental health.

o Increase the commitment to de-centralisation through opening psychiatric units in the remaining regional hospitals. Provide outreach from the regional hospitals to support mental health at the district level.

o Develop rehabilitation within mental health services, such as half-way houses or vocational rehabilitation, in order to facilitate the social integration of people with mental illness and prevent relapse.

o Draw on lessons from anti-stigma campaigns in HIV/AIDS and disability in order to raise public awareness of mental health and tackle stigma.

o Integrate mental health into existing structures for primary care provision and public health education and case detection. Train all health workers in mental health, including all workers in primary care.

o Provide a comprehensive training programme for mental health professionals to update their skills so as to continue to provide best practice in mental health care.

o Develop recruitment and retention strategies for mental health staff to address the attrition of mental health workers.

o Develop new mental health policy in line with draft mental health bill. This should be built on extensive consultation with all stakeholders.

o Promote mental health policy in the context of other relevant policy, and increase collaboration with other relevant sectors in the treatment of the mentally ill.

o Provide training for those whose work brings them into contact with the mental health problems, such as the police, teachers and social workers.

o Develop information systems for collating data on mental health, and monitoring and evaluation of services.

- o Disseminate mental health policy to all levels within the health service, as well as other relevant sectors, and provide training and education to those responsible for policy implementation.

1. Introduction

In the year 2000, it was estimated that mental disorders contributed 12% of the global burden of disease and it is predicted that this will rise to 15% by the year 2020. Currently mental disorders make up 5 of the 10 leading causes of health disability, and by 2020 it is predicted that unipolar depression will be the second most disabling health condition in the world (Lopez et al. 2006). It is estimated that 1 in 4 people suffer from a diagnosable mental disorder during the course of their lifetime (WHO 2004).

There is no comprehensive data on the incidence and prevalence of mental disorder in Ghana. However it is estimated that at least 13% of the adult population are likely to suffer from a mental disorder, with 3% of these suffering from a severe mental disorder and 10% suffering from a mild to moderate mental disorder (WHO 2007).

There is emerging evidence from low-income countries that mental illness is strongly associated with poverty and many aspects of social deprivation associated with poverty (Flisher et al. 2007;Lund et al. 2007). Mental illness is associated with food insecurity (Patel et al. 1997), inadequate housing (Araya et al. 2003;Reichenheim & Harpham 1991), unemployment (Abas & Broadhead 1997;Araya et al. 2001;Inandi et al. 2002), low levels of education (Araya, Lewis, Rojas, & Fritsch 2003), social fragmentation (Harpham, Grant, & Rodriguez 2004) and violence (including domestic violence) (Fleitlich & Goodman 2001;Harpham et al. 2005;Seedat et al. 2004;Stein, Seedat, & Emlsey 2002;Ward et al. 2001). Indeed researchers have described the interaction of poverty and mental illness as a "vicious cycle" in which the conditions of poverty lead to high levels of stress, social exclusion, reduced access to social capital, malnutrition, obstetric risks, increased risk of violence, and thereby to increased prevalence and worse outcomes for mental disorders. In turn, mental illness leads to increased health expenditure, reduced productivity, job loss, and social drift into poverty (Patel 2001).

Despite some significant economic growth in recent years (World Bank 2007), Ghana is classified as a low-income country with 28.5% of the population living in poverty, and 18.2% living in extreme poverty. However these figures conceal significant regional variation between the urban coastal areas and the northern regions, with

87.9% of the population of the poorest region, Upper West, living in poverty, compared to 11.8% in the capital (Government of Ghana, 2007).

In spite of these disturbing trends and the growing burden of mental ill-health, there are encouraging signs that cost-effective interventions are available. During the last 40 years, anti-psychotic medications have revolutionised the care and treatment of people with schizophrenia and bipolar mood disorder, in a way that allows most people with these conditions to live relatively normal lives in the community (WHO 2001). Cost-effective generic medications are now available for people suffering from common mental disorders such as depression and anxiety (Patel et al. 2003;Patel, Araya, & Bolton 2004). Advances in a range of psychosocial interventions have been made and documented (WHO 2001). Although many of these psychosocial interventions have been developed in western settings, several have been adapted and found to be effective in Africa and in many low- and middle-income countries (Bolton et al. 2003;Patel 2007;Siskind, Bolton, & Kim 2007). The development of psycho-social rehabilitation (PSR) provides new directions for recovery, empowerment and re-integration into communities after periods of mental illness (WHO 1996).

Beyond the clinical realm, there is emerging evidence that wider social and economic interventions can have a positive benefit for the mental health of communities. For example, the introduction of pensions in South Africa was shown to reduce levels of depression in households where pensioners resided (Case 2004). Internationally, welfare benefits have been shown to reduce rates of common mental disorder among recipients (Plagerson et al. 2008). Participants in a micro-credit scheme in Bangladesh have shown reduced rates of emotional stress among women following 7 years of participation in this scheme, compared to non-participants (Ahmed, Chowdhury, & Bhuiya 2001). Education has shown a strong dose-response relationship in reducing rates of common mental disorders in low and middle-income countries (LMICs) (Araya, Lewis, Rojas, & Fritsch 2003).

Nonetheless despite the burden of mental illness and its association with poverty, disability and social exclusion, mental health remains a low priority in Ghana. Mental health policy and legislation are outdated, and financing for mental health is inadequate to meet the needs of the population. Mental health services continue to labour under institutional patterns of care, when international trends are towards the downscaling of psychiatric institutions and the provision of community-based mental

health services (Geller 2000;Thornicroft & Tansella 1998). Decentralisation of mental health services has only occurred on a limited scale, and community-mental health services are inadequate. Mental health care remains focused on pharmaceutical treatment, with little provision for psychosocial interventions, including psychosocial rehabilitation. Whilst a new mental health bill has been drafted, there are concerns as to when it will be passed, and to what extent the bill will be implemented in practice.

In conclusion, whilst there is likely to be a significant burden of mental illness in Ghana, much of this remains untreated by mental health services. However despite some efforts towards the reform and expansion of mental health care, little progress has been made. Mental health policy appears to have promised more than it has been able to deliver in practice, largely due to the lack of human and financial resources with which to fulfil its objectives.

Key research questions are therefore:
- o What is the process of mental health policy making in Ghana?
- o What is the content of mental health policy and what is its status?
- o How much of a priority is mental health for the Ghanaian government?
- o What are the processes of implementing mental health policy and legislation? How successful are these processes at national, regional and district level? What is the current situation regarding mental health service provision?
- o What is the opinion of a range of key stakeholders in mental health regarding mental health priorities and current policy?

The **aims of this research** are:

- o to describe and understand the broad context in which mental health policy-making takes place in Ghana,
- o to understand the general situation regarding mental health needs and priorities,
- o to assess the wider policy-making practices in the public sector,
- o to describe and analyse the development of mental health policies and mental health law,
- o to assess the appropriateness of the mental health policies and mental health law, including the involvement of stakeholders and their influence on the formulation of mental health policies and mental health law,

- o to assess the practices of implementing mental health policies and law at national and regional level, and
- o to assess the implementation of the mental health policy and law at district level.

The remaining chapters of this report will set out the methodology, results, discussion and conclusions of the study.

This research is conducted in the context of a wider international study of mental health policy development and implementation in 4 African countries: Ghana, South Africa, Uganda and Zambia (Flisher, Lund, Funk, Banda, Bhana, Doku, Drew, Kigozi, Knapp, Omar, Petersen, & Green 2007). This study, titled the Mental Health and Poverty Project (MHAPP), sets out 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. This report presents the findings of the first phase of the study, namely a situation analysis of mental health policy development and implementation in Ghana. The findings of this first phase will be used to inform a set of interventions, developed in partnership with the Mental Health Unit at the Ministry of Health. The interventions conducted in the second phase will set out to address particular barriers to the successful development and implementation of mental health policy in this country. These interventions will be documented and evaluated, with a view to generating lessons that may be of value for future work in Ghana and in other low- and middle-income countries.

2. Methodology

2.1 Introduction

2.1.1 Conceptual background to the methodology

In developing the methodology for this study, a conceptual framework for understanding mental health policy development and implementation was formulated by the research consortium (Flisher, Lund, Funk, Banda, Bhana, Doku, Drew, Kigozi, Knapp, Omar, Petersen, & Green 2007). This framework was used to guide our analysis of mental health policy development and implementation in Ghana, the data sources we explored, and the stakeholders we interviewed.

In the development of policy, it is critical to align the policy with the mental health needs, context and particular health system of the specific country. By mental health policy we mean an organised set of values, principles, objectives and areas for action to improve the mental health of a population (WHO 2005a). The likelihood of the policy being appropriate and feasible will depend on the processes by which it was developed and in particular, the extent to which it has included key stakeholders within this process (Walt & Gilson 1994). It will also depend on the degree to which the policy is evidence-based.

In the implementation of policy, the existence of an appropriate policy may be a necessary condition for improved services, but is, of course, not sufficient. Three barriers to the effective implementation of policies are commonly experienced. Firstly, the policy itself may be too general and not be turned into a strategic plan or programme. Secondly, the appropriate health system may not be in place to support the policy. The third key constraint can be, at best, a lack of support for, or at worst, resistance to, the policy and programme at the implementation level. Such a lack of ownership may be experienced from a number of groups including professional groups, health service managers, service users or the wider community, partly due to the stigma often associated with mental illness.

Mental health is the product of a number of determinants, which may have their origins beyond the formally designated health sector. Hence there is a need for a multi-sectoral approach to both policy development and implementation. The Ministry

of Health needs to take the lead in adopting a multi-sectoral approach and developing appropriate tools and relationships for working with district health systems and with non-governmental and private providers.

2.1.2. Research methods and instruments

The study makes use of quantitative and qualitative methodologies. Data collection employed the following methods:

1. The **World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2** was completed to assess mental health resources such as budgets, beds and staff, and service utilisation.

2. Document analysis of mental health policy, plans and legislation utilising the **WHO Mental Health Policy and Plan Checklists** and the **WHO Mental Health Legislation Checklist**.

3. **Semi-structured interviews and focus group discussions** with key stakeholders in mental health were undertaken to provide an understanding of the process of mental health policy development and implementation and key issues and challenges in mental health in Ghana.

4. Analysis of recent research with users of government mental health services.

Findings were triangulated where possible, using two or more sources of data or research methods. The fieldwork for the study was conducted between 14th September 2006 and 30th August 2007. Data for the WHO-AIMS was collected for the 2005 index year. Analysis and writing up was conducted from 1st June – 30th September 2007.

The four methods and the instruments employed are described in turn below.

2.2 WHO-AIMS

2.2.1. Brief Description of the WHO-AIMS Instrument

Quantitative data regarding the mental health system in Ghana was gathered using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2 (WHO 2005b).

The WHO-AIMS tool has been developed to assess key components of a mental health system and thereby provide essential information to strengthen mental health systems. The instrument was developed following the publication of the World Health Report 2001 (WHO 2001), which focused on mental health, and provided a set of recommendations. These recommendations address essential aspects of mental health system development in resource-poor settings. WHO-AIMS 2.2 consists of 6 domains (covering the 10 World Health Report 2001 recommendations comprising 28 facets and 156 items). The 6 domains are interdependent, conceptually interlinked, and somewhat overlapping. All 6 domains need to be assessed to form a relatively complete picture of a mental health system. The domains include:

- Domain 1: Policy and legislative framework
- Domain 2: Mental health services
- Domain 3: Mental health in primary care
- Domain 4: Human resources
- Domain 5: Public education and links with other sectors
- Domain 6: Monitoring and research

The instrument includes the WHO-AIMS Excel Data Entry Programme and a template for a narrative report. The WHO-AIMS seeks to identify mental health services using a number of standardised definitions for terms such as 'mental hospitals', and 'community-based inpatient services' which it proposes are mapped onto local services (See Appendix 1 for a full list of definitions used in WHO-AIMS).

2.2.2 Sampling and procedure for WHO-AIMS

Respondents were purposively sampled from amongst policy makers, programme directors and other major stakeholders in mental health at the national level. To facilitate ease of response, the 156 facets of the WHO-AIMS were changed from statements into question format. There was also some debate regarding how to

match local service provision to the WHO-AIMS definitions. The research team jointly agreed which services would be matched to which definitions, for example 'community-based inpatient services' were equated to the psychiatric units in general hospitals. The questionnaire was then allocated to respondents, according to the relevance of the questions to the respondent's area of responsibility. Some of the questions were sent to multiple respondents if it was felt that they had access to the relevant information. Where their responses tallied it increased confidence in the data. Where the responses were inconsistent with each other, they were cross-checked until the most plausible answer was found. In some cases the questionnaire was completed together with the researcher. Other respondents completed the questionnaire independently.

48 respondents completed the questionnaire. These included:

- The Acting Chief Psychiatrist
- A retired Chief Psychiatrist
- The Medical Directors of Ankaful Psychiatric Hospital, Accra Psychiatric Hospital and Pantang Hospital
- The National Coordinator of Community Psychiatric Nurses
- The Coordinator of Community Psychiatric Nurses, Greater Accra Regional Health Directorate
- The head of the Department of Psychiatry, University of Ghana Medical School
- The Director of Public Health Division, GHS
- The Director of Institutional Care Division, GHS
- The Director of Legal Drafting, Attorney General's Department
- The Deputy Director of Pharmaceutical Services, Accra Psychiatric Hospital (responsible for psychotropic drugs at the national level)
- The Ministry of Finance
- The Chief Accountant, Accra Psychiatric Hospital
- The principal pharmacist, Pantang Hospital
- Social Welfare unit at Accra Psychiatric Hospital
- Basic Needs Ghana (NGO)
- Psychomental Association (NGO)

2.2.3 Analysis of WHO-AIMS data

Data from the questionnaires was entered into the WHO-AIMS Excel spreadsheet. Numerical data were aggregated under the relevant headings. Some of the data could not be aggregated due to differences in the collection of statistics between services. For example, Accra and Ankaful Psychiatric Hospitals compile records of those treated under the age of 19, whereas Pantang Hospital compiles records of those under 17. Descriptive statistical analyses of relevant items were conducted. Nationally aggregated responses to items were then entered into the WHO-AIMS narrative template.

2.3 Document Analysis

Document analysis was conducted in two broad forms:
- o Formal analysis was conducted of key policy and legislation documents, using the WHO Mental Health Policy and Plan Checklist and the WHO Mental Health Legislation Checklist.
- o Background literature relevant to mental health policy development and implementation in Ghana, including other relevant policy documents, were reviewed to provide an understanding of the policy context.

2.3.1 WHO Mental Health Policy, Plan and Legislation Checklists

The WHO Checklist for Mental Health Policy and Plans and the WHO Checklist for Mental Health Legislation are designed to assess the content and process of developing mental health legislation, policy and plans according to a number of criteria.

The Ghana team that reviewed the checklists included the following:
1. The Co-Principal Investigator of the MHAPP
2. The MOH representative on the MHAPP
3. The MHAPP Research Officer for Ghana
4. The National Coordinator of Community Psychiatric Nurses
5. The Deputy Director of Nursing Services, Accra Psychiatric Hospital.

The committee sat for two days to go through the checklists and completed the entries in the template sheet provided (see Appendix 2).

The documents used for evaluating the checklists included:
- The 1972 Mental Health Decree of Ghana
- The 1994 Mental Health Policy
- Five Years 2007-2011 Mental Health Programme of the Mental Health Unit in collaboration with the Ministry of Health
- The 2006 draft Mental Health Bill

2.4. Semi-Structured Interviews and Focus Group Discussions

2.4.1 Sampling and procedure for semi-structured interviews and focus group discussions

Interviews and focus group discussions were conducted intensively over a five-month period at the national (macro), regional (meso) and district (micro) levels. Respondents were purposively sampled from among the major stakeholders in mental health care in Ghana within five of the ten regions: Greater Accra, Central, Ashanti, Brong Ahafo and Northern regions. A sample district, Kintampo North, was selected for interviews and focus group discussions at the micro level. Interviews and focus group discussions were conducted with policy makers, programme directors, researchers, academics, health professionals, traditional healers, teachers, journalists, police officers, NGOs and religious leaders.

In all 122 respondents supplied information in the form of in-depth interviews and focus group discussions as illustrated in the following table:

Semi-Structured Interviews				*Focus Group Discussions*		
Macro	*Meso*	*Micro*	*Total*	*Macro*	*Micro*	*Total*
35	23	23	**81**	1	6	**7**

(See Appendix 3 for samples of the interview schedules and focus group guides.)

The semi-structured interviews were tailored according to the specific individual being interviewed. The following generic areas were covered:

1. Major development challenges facing Ghana
2. Key challenges facing the health system
3. Perceptions of mental health
4. Mental health needs and priorities in Ghana
5. The role of stigma in mental health
6. The role of government in addressing mental health needs
7. General policy making process in Ghana
8. Process of mental health policy and legislation development.
9. Role of various stakeholders in mental health policy and legislation development
10. Content of the current mental health policy and legislation
11. Implementation of mental health policy and legislation at the national and regional levels
12. The research agenda for mental health.

2.4.1.2 National and regional level

There were 35 semi-structured interviews at the national level, and 23 at the regional level. 1 focus group discussion was conducted at the national level.

Respondents at the national level were drawn from:
- The Ministry of Health
- The Ministry of Manpower, Youth and Employment
- The Ministry of the Interior
- The Ministry of Information
- The Ministry of Public Sector Reforms
- The Ministry of Justice
- University of Ghana
- Kintampo Health Research Centre (GHS)
- Health Research Unit (GHS)
- Psycho-mental Association (NGO)
- Accra Psychiatric Hospital
- Senior nursing officers (GHS)
- National Health Insurance Scheme

- Ghana Police Service
- Presbyterian Church
- A national newspaper
- The World Health Organisation (Ghana Country Office)

Respondents at the regional level were drawn from:
- Regional hospitals
- Regional Health Directorates
- Community Psychiatric Nurses
- Ankaful Psychiatric Hospital
- Pantang Hospital
- Nurse training schools
- Psychiatric nurses' training colleges
- Kwame Nkrumah University of Science and Technology
- Private psychiatric hospital
- Basic Needs (NGO)

2.4.1.2 District level case study site: Kintampo North

Kintampo North district in a rural area of Ghana was chosen as a representative case study to examine the implementation of mental health policy at the micro level. Kintampo district was selected as it has significant levels of poverty, and very limited provisions for mental health care. Whilst there are other districts in Ghana with a greater provision of mental health services through the provision of CPNs and the intervention of NGOs, Kintampo is not untypical in having no dedicated psychiatric services. Kintampo was also selected as it has a supportive infrastructure for health research. It is the location for Kintampo Health Research Centre, one of four health research centres within Ghana Health Service, and is also host to the Kintampo demographic surveillance system (DSS) which is a member of the international network of field sites with continuous demographic evaluation of their populations and their health (INDEPTH network: www.indepth-network.org).

Kintampo North District (formally Kintampo district but since 2006 politically demarcated into Kintampo North and Kintampo South Districts) is one of the 19 districts of the Brong Ahafo region of Ghana. It is located in the forest-savannah transitional ecological zone within the middle belt of Ghana. At 4,000 sq.km, Kintampo North is one of the largest districts in the Brong Ahafo Region. Kintampo

town, the district capital, is located at the geographical centre of Ghana and forms a major hub for both international and domestic passenger and freight transport. The town is the location for the district hospital.

The population of the district stands at 140,000. This population is found in 22,475 households, spread over 4,000 compounds. The district has a growth rate of 2.6% as of January 2006. The largest ethnic group of the area are the Bono or Brong who form approximately 40% of the local population, followed by the Mo who form about 20%. There is a significant immigrant population from the Northern regions, including Dagomba, Sissala, Kokomba, Grushie and Dangbe, as well as the descendants of Mossi and Hausa traders and a number of Fulani pastoralists who herd cattle in the district.

A sub-group of the Akan, the Bono speak a variant of Twi which is also spoken as a second or third language by members of other ethnic groups. As elsewhere in Ghana, Hausa is the lingua franca among northern immigrant groups. There are high rates of illiteracy in Kintampo, particularly among women, with over half of the population never having attended school.

According to official data about 50% of the population of Kintampo district are Christian, just under 30% Muslim (including the majority of Northern migrants), and 10% 'traditionalist', that is followers of the indigenous religion[1]. However religious practice is diverse and many may combine traditional and Christian or Muslim practices.

Farming is the major economic activity for approximately 80% of the inhabitants, mainly as a result of the abundance of fertile land and favourable rainfall pattern. Many farmers are engaged in subsistence level agriculture. Cash crops include timber, yams, cashew nuts, mangoes and cocoa, however many families grow foods for household consumption such as yams, cassava, maize and onions. Kintampo has a large food market on Wednesdays. Traders from all over Ghana and neighbouring countries converge to buy foodstuffs and sell a variety of commodities, from agricultural products to textiles and electrical appliances.

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[1] Figures taken from the website www.ghanadistricts.com, produced in partnership with the Ministry of Local Government.

There are high rates of poverty in the district and many households lack basic amenities such as water and electricity. Transport is difficult as roads are largely unpaved, and there is poorly developed infrastructure.

At the district level, there were a total of 23 semi-structured interviews and 6 focus group discussions. 16 of the interviews were conducted in English and 7 were conducted in Twi, the local language in the study district and the most wide-spread language in Ghana. The focus group with traditional healers was conducted in Twi. All other focus groups were in English.

In-depth interviews were conducted with representatives of the following groups:
- o District Health Management Team
- o Ghana Education Service
- o Health professionals
- o Users of psychiatric services
- o Social workers
- o Faith healers (Christian and Islamic)
- o Traditional healers
- o School teachers
- o Police
- o Member of judiciary

Focus group discussions were conducted with the following:
- o Nurses from the district hospital
- o Teachers – 1 private school, 1 public elementary school, I secondary school
- o Police
- o Traditional healers

2.4.2. Analysis of interviews and focus group discussions

All the interviews conducted were digitally recorded with participants' consent. However four respondents refused to be recorded and written notes were taken.

Interviews were transcribed verbatim. Interviews in 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 analysis.

A cross-section of the interview transcripts were purposively sampled and sent to respondents to ensure that the transcripts accurately represented their views. Among the respondents who read their interview transcripts, none demanded that anything should be changed.

A framework analysis approach was adopted (Ritchie & Spencer 1994) in which certain themes were agreed upon by investigators from all four study countries. These themes were based on the objectives of the study (as set out in the introduction). From these objectives, sub-themes were suggested by 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 (See Appendix 4 for the coding frames employed). 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%.

2.5 Research Ethics

The protocol was submitted to the Scientific Review Committee of Kintampo Health Research Centre for scrutiny of the scientific merit of the study. Ethical approval was granted by the Ghana Health Service Ethics Committee at the national level and the Institutional Ethics Board at Kintampo Health Research Centre (see Appendix 5 for copies of approval letters).

Information sheets containing essential information on the study and the implications of participation were submitted to all participants. Participants were then requested to sign a consent form to indicate their willingness to participate in the study (See Appendix 6 for examples of information and consent forms). Participants who were unable to read had a witness read the information sheet and consent form to them in Twi before agreeing to participate in the study. These participants 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 have been removed in order to protect their confidentiality.

3. Results

The results are presented below according to themes drawn from the interviews and focus group discussions, as well as quantitative data from the review of Ghana mental health legislation and policy, and the completed WHO-AIMS. To strengthen the voices of users in the report, special mention is made of research with users of mental health services. Issues of concern to them are compared with those of users of regular health services who have chronic physical illness.

3.1 Context

This section presents the findings of the study regarding the broad context of the mental health system in Ghana. In the interviews, respondents were asked to give their opinion on the context within which mental health may be situated in the country and the major development priorities and challenges. The following themes were those which recurred most frequently, or which produced the most comment amongst participants:

- Current health policy
- Poverty and development
- The burden of disease
- Human rights
- Traditional and faith healers

3.1.1 Current health policy

In 2005 the Ministry of Health produced a policy on the implementation of an initiative called Community-Based Health Planning and Services or CHPS. CHPS aims to improve community access to basic health care, advocating that the Ministry 'moves health services to community locations, develops sustainable volunteerism and community health action, empowers women and vulnerable groups, and improves health provision through household and community interaction with service workers'. The focus of CHPS is on promotion and prevention, and case detection and referral. Community Health nurses are retrained as Community Health Officers (CHOs). They are expected to develop links with families, community leaders, traditional authorities and traditional health practitioners within the communities within which they work to improve equity in access to basic health services and develop effective intersectoral

collaboration. They are supported by Community Health Volunteers (CHVs) whose duties include community education, health promotion, environmental sanitation, immunization assistance and health record keeping (Ghana Health Service 2005).

Several respondents echoed this grassroots approach to health promotion:

> *'The key health problems in this country, I feel those problems if we had good health education and the preventive aspects were effective, personal hygiene, environmental hygiene were very effective, probably it would have reduced the common illnesses like malaria, typhoid fever which are also related to mental illness somehow. It would have reduced… and so education is very, very important....*
> *(Respondent 55, senior psychiatric nurse, regional hospital)*

Many respondents situated mental health within the context of general health policy in Ghana. The current emphasis by the Ministry of Health in Ghana on health promotion and illness prevention was linked directly to mental health by some respondents who suggested that mental health should be more integrated into the public health agenda. Like the respondent quoted above, another suggested that rather than funding psychiatric care in institutions, the government should focus on mental health promotion through public education in the community to address potential risk behaviours:

> *'That is why maybe we have mental health cases increasing because if government has attention for mental health, maybe it could be not necessarily funding psychiatric hospitals or institutions, but maybe public education on what things… what leads to this mental disorders. We know… I mean basically smoking narcotics and those things. If there is a lot of government commitment, maybe even education beginning at the lower levels, can even prevent the increasing numbers we are having.'*
> *(Respondent 27, national newspaper editor)*

Some participants referred directly to CHPS as a model for the provision of mental health promotion and education at the community level. Grassroots activities such as radio broadcasts, durbars and talks in churches and schools, were some of the

strategies cited by participants to carry out public health education in the communities.

3.1.2 Poverty and development

Several respondents referred to the position of mental health within the context of widespread poverty in Ghana. Many contrasted the levels of development in the country between rural and urban areas, and between the north and the south of the country. Rural areas were generally seen as excluded from policy development, even though this is where the majority of the population of Ghana live. The north of the country was also seen to be relatively neglected in policy due to its distance from the centres of power in the south.

This bias is reflected in mental health care in which all the psychiatric hospitals are located in urban areas of the south. Respondents identified those from the north and rural areas of the country as being poorer and generally less well educated.

It was observed that whilst many programmes seek to address poverty and social exclusion in Ghana, mental illness is generally overlooked in the development agenda. Though reference is made to the 'marginalized' and 'vulnerable' in development programmes, those with mental illness are rarely included within such definitions:

> *'… mentally ill people largely are not part of development processes,*
> *so there are countless organizations and even government projects*
> *that target poor and marginalized, but most of them hardly really*
> *think about mentally ill people. ……..,when they are talking about*
> *this, possibly they are talking about people with physical disabilities.'*
> *(Respondent 57, director, mental health NGO)*

3.1.3 The burden of disease

A common theme which emerged in the interviews concerned the low priority of mental health compared to other serious health problems in Ghana such as malaria, malnutrition, maternal and child mortality and communicable diseases such as TB. Respondents pointed out that in the context of the high disease burden in the country there is competition for resources. Conditions which were seen to have higher

morbidity and mortality receive greater priority from the government and attract more funding :

> *'Broadly we have children dying, we have mothers dying, we have young people dying prematurely and we have people aging quite faster, you know ageing, they don't age healthily. They* [these deaths] *are related to nutrition, they are related to communicable diseases, they are related to reproductive health issues. Those are the main health problems.'*
> *(Respondent 6, programme director, MOH)*

> *'....malaria, diarrhoeal diseases, the pneumonia diseases, they take the chunk, because when you go to the records in the hospitals, health facilities and the rest, they are most of the time the top five diseases that report. So these ones have taken prominence, far more prominence over other disease issues.'*
> *(Respondent 18, senior health researcher)*

Other health concerns which were perceived to take precedence over mental health included HIV, respiratory tract infections, road traffic accidents, and emergent non-communicable conditions such as hypertension, diabetes and cancer. Nobody mentioned mental health spontaneously as one of the disorders that required priority attention in Ghana. As expected, conditions mentioned by respondents at the policy-making level reflect recent Ministry of Health statistics fairly accurately. Between 2001 and 2006 the five leading causes of morbidity at outpatient consultations were malaria, upper respiratory tract infections, diarrhoeal diseases, skin diseases and hypertension. Accidents formed the sixth leading cause of consultation However there appears to be an underestimation of the incidence of mental disorders. In 2006 mental disorders were recorded as forming 1.15% of outpatient morbidity. This is far below the percentage recorded for malaria (37.83%), and lower than the other top five conditions (6.20% for upper respiratory tract infections, 3.38% for diarrhoeal diseases, 3.34% for skin diseases, 2.78% for hypertension and 2.27% for accidents). Nonetheless this ranks mental disorders as the twelfth most common cause of outpatient consultation, above gonorrhoea, pneumonia, gynaecological disorders, malnutrition and communicable diseases such as typhoid, hepatitis and tuberculosis, and close to pregnancy and related complications which formed 1.34% of consultations in 2006. This figure also marks a significant rise from 0.17% in 2005

which may be due to changes in the recording of mental disorders within outpatient departments due to the introduction of new health information software (Ministry of Health Ghana 2007).

Some respondents felt that mental health was barely considered within the Ministry of Health compared to other health concerns:

> *'Mental health in Ghana is an area that the ministry….. the ministry does not attach any great importance to it. Yet, you see the other areas like the MCH or the disease control, the nutrition and other areas, being well catered for than the mental health. Mental health has a lot of problems and the way mental health is being treated it's as if it is not part of the health services in the country.'*
> *(Respondent 2, senior psychiatric nurse, regional level)*

3.1.4 Human rights

Many respondents talked about mental health in the context of human rights. A majority of respondents reported that those who are mentally ill are frequently denied their basic rights simply because of the nature of the illness:

> *'People abuse the rights of the mentally ill person because they think when he is mentally ill he has no rights again. His rights have been taken away from him.'*
> *(Respondent 66, senior police officer, district level)*

Respondents pointed out that current legislation in Ghana, including mental health legislation, did little to protect the rights of the mentally ill. Despite provisions for the protection of human rights for all Ghanaian citizens in the Ghanaian constitution, those with mental health problems were excluded from many opportunities, including the right to vote:

> *'Well, I mean, as you are aware, they can't vote. So it means they don't have equal rights [….] there are certain areas and certain aspects that they cannot actively participate. So they don't have equal rights and equal opportunities because opportunity to vote is restricted.'*

The abuse of human rights across all mental health treatment facilities and institutions in Ghana was discussed by many of the respondents. Human rights abuses were reported to occur at most places where mental health services are provided including traditional healers, faith healers and government psychiatric services. These include the chaining of those with mental health problems, forced fasting and beatings. Some of these abuses are acknowledged to occur when those who are mentally ill became agitated or aggressive and there are no other available means of restraining or calming them:

> *'….people were trying to do their best to help people with mental illness, but when there is inadequacy and all those things set in, we don't intentionally try to violate people's rights. But when you keep someone in the mental hospital then you can't provide for the person, you then of course, you are violating that person's rights. Or ……..if you have a child and the person is being violent and the only way you can control that person is to chain that person…'*
> *(Respondent 16, World Health Organisation)*

Several respondents also criticised the quality of care within the psychiatric hospitals and other health care facilities. Human rights abuses against the mentally ill in health facilities were attributed by one respondent to the limited numbers of staff and the lack of training:

> *´If you go into our health facilities, the intention is not to discriminate against the mentally challenged people, but I think it is the lack of personnel. So you may find people in the health facilities who are trying to handle these mental cases but do not know the best way to handle them."*
> *(Respondent 18, senior academic researcher)*

In the psychiatric hospitals, seclusion and physical restraint was reported to occur as a result of the unavailability of sedating medication, or shortage of staff. Over-crowding in the psychiatric hospitals was reported to lead to inhumane and unsanitary conditions. Some complained that the stigmatization of mental health

meant that violations of the person's rights was more common within psychiatric care than elsewhere in the health system:

> '…I don't think you will walk into any other hospital and see someone lying on the floor, unless these days when the ward gets full, but here gradually maybe because of congestion and because you think the people are mentally ill, (sebe wabo dam) [he might be mad] if he is lying on the floor somewhere, nobody cares'
> (Respondent 16, World Health Organization)

Furthermore, it was also noted that the right of access to care is strongly jeopardized by the inaccessibility of mental health services and, in particular, the lack of psychosocial services in most parts of the country:

> Interviewer: 'Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people?
> Respondent: 'No, I don't, because we don't have the people to handle such cases, so how do they enjoy the same? If there is a psychiatric doctor and an ordinary medical officer, fine. Anytime they [the patients] come, there would be someone there to handle them. If there is an SRN [State Registered Nurse] and there is RMN [Registered Mental Nurse] then they are enjoying the same facilities, but once we only have the RMN, we have the medical officer, we do not have the psychiatrist, the psychoanalyst, the psychologist, they are not given….you know, that aspect are not given the needed attention at all.'
> (Respondent 62, senior public health nurse, district level)

3.1.5 The role of traditional and faith healers

Many respondents referred to the pluralistic system of health care in Ghana, in which traditional and faith healers are major providers. Traditional and faith healers were identified by many respondents as playing an important role in the treatment of mental illness, a far more significant role in fact than orthodox health services:

'I would say that a greater percentage of all cases of mental illness are addressed by healers and fetish priest organizations, and so by virtue of their presence and number of cases they see, you cannot easily brush them aside. So they play a very, very big role.'
(Respondent 57, director mental health NGO)

'They are the first point of call... People go to them first and they have their own interpretation and management systems for mental health. Some work, some do not work, but they are usually the first point of call, and they are usually the last point of call.[....].People think that mental health is not physical it is spiritual and they believe these are the custodians of spiritual issues so they go to them. So they have a very important role to play.'
(Respondent 6, director of department, MOH)

Respondents indicated that people approach traditional and faith healers for various reasons. In the case of mental health they may be the most easily accessible form of care when access to mental health facilities and professionals is not a practicality. However, many people who live within easy reach of psychiatric facilities, for example in Accra, also use traditional healers. This may be because of the belief that mental illness is a spiritual illness which requires spiritual treatment:

'… there are people who live in Accra who would get up and go to a traditional healer in the village somewhere. It is not because of access, it is not only because of access, I think it is a mixture of several factors. For some people it might be because of access, for some people it might be because of religious beliefs, for some people it might be because of their perceptions of disease causation. I mean it is multi-factorial… I don't think you can just limit it to access.'
(Respondent 5, senior academic health researcher)

'If they fall ill, one of the first things that they think about is the supernatural forces, it's like something is happening to me because somebody else is part of it, and because they hold that belief they end up at the traditional healers, you know, the shrines, the religious prayer camps and something like that.'

Traditional healers were seen as filling a 'yawning gap' in mental health service provision, particularly in providing psychosocial and spiritual support:

> *'….traditional healers don't just tell…give you the physical causes, they give you the supernatural causes of your illness and so they are sometimes able to allay the fears of people and then go on to address those psychological problems, because sometimes they are possibly not drug-related conditions that need to have medications, or possibly some talking therapy, being able to understand where the person is coming from in terms of his own psyche and the rest, and they are able to adequately address this for them […..] But to a large extent, because of what people think is the cause of mental illnesses, they are able to go there, and the other most important thing is that people who are professionals and could have helped are woefully inadequate. So these people fill the gap. A very, very big yawning gap. Even if it is not adequate, if it is not to the best of standards, how many psychiatrists are in the three northern regions? How many clinical psychologists are available to people? So that is it. So that is why you just cannot brush them aside.'*
>
> *(Respondent 57, director, mental health NGO)*

As in the last quotation, some respondents saw the psychosocial and spiritual approach of traditional and faith healers to be complementary to biomedical treatment:

> *'...... some of the mental cases need somebody talking to them. I mean if you go to some of the spiritual healers and those kinds of things, like the churches and those kinds of things, the psychology of preaching to you, of telling positive things, may rekindle you and bring you to normalcy, even without medication. If there were readily available medications for treatment of cases and these were supported by such spiritual roles, I think that it will do a lot of good to the mental cases.'*
>
> *(Respondent 18, senior health researcher)*

Several mental health practitioners, such as this CPN, reported working successfully in partnership with traditional and faith healers, visiting the shrines and churches and providing advice and education:

> *'…the traditional and faith healers? This people they are useful. Some…. you know, in our society we believe in this spiritualist and the fetish and these things, so some of our clients no matter what you do, no matter how well they become, some of them will like to visit them and we don't deny them that. All that we are interested in is taking your medication from our side whilst you are attending for treatment from the other side too. So when our clients are maybe admitted at such places, if only we are informed by their relatives or the caregivers, we do pay them visits. We talk to either the spiritualist, the fetish priests, or whatever it is, we talk to them, we chat with them, they are friends, and even some of them this time they encourage the relatives and the clients to come for treatment whilst they are there.'*
>
> *Interviewer: 'For problems that they think they cannot deal with?'*
>
> *Respondent: 'Yes. So this time, or when they see that the person's condition is delaying, you see, then they ask them to come. But we tell them that there are conditions, especially the acute phase, where the person may be very restless or aggressive, they should know that is not their area. That side they cannot do much about it, so they should convince them to come to the hospital. After the person has settled, the person can be there and be receiving our treatment there and they will also be taking care of the spiritual side.'*
>
> *(Respondent 2, Community Psychiatric Nurse, regional level)*

Many respondents, even at the policy-making level, advocated such collaboration between the 'clinic-based setting' and the 'faith-based setting' as a means of providing a holistic balance of care between psychiatric services and traditional and faith healers:

> *'I think, whether you like it or not, people are going to them, and because of our traditional beliefs and things, the first point of call*

when people have mental illness is to go to these traditional healers and faith healers because they think they are being bewitched or something is happening to them, which they have to seek for the causes. Most people would not even go to the hospitals and clinics. First, they would go there sometimes when they are well sorted out before they come to the hospital. So we are saying, whether you like it or not, people are going there, that is why we should involve them and perhaps do some kind of training for them, and also collaborate with them, so that even when they come to their place, like faith healers, even though they are praying for that person and the church, at least the Pastor can advise that: "See your doctor, take your medication, come back to the church, and let's pray". So I think we need to involve them and collaborate with them a lot.'
(Respondent 16, World Health Organization)

'…where I have seen successful management of mental cases is being the link between the two - where the church encourages the patients to take their drugs and, you know, keeps monitoring them, and create the environment for them to be aware of the fact that they have a problem that requires treatment, but that is where it ends. And so we need to be able to strike that kind of relationship between the clinical setting and the faith-based setting.'
(Respondent 21, programme director, MOH)

However concerns were raised by many participants about the human rights abuses that can occur in the prayer camps and traditional shrines. Clinicians reported that persons with acute cases of mental illness are often chained, beaten and forced to engage in fasting. This nurse outlined in detail some of the consequences of such maltreatment and reported that people with mental illness may even die from the beatings they have received from traditional healers:

'The traditional healers, some of them have been doing well because some of them now, the CPNs have liaised with them so when conditions that they feel is getting worse, they call them. Even sometimes they call them and ask them for some of the drugs to be given to the patients while the patients are there. But others too feel they know everything, so they chain the patients at the mercy of the

weather whether it's raining, whether it's shining, and the patients will be maybe chained to a tree and even the side where it's chained, sometimes they develop sores, sometimes gangrene, sometimes because of the struggle they have fractures and sometimes even in the hot sun they say that they want to exorcise for the…..they believe that some spirits, sometimes ancestral spirits, sometimes familiar spirits, sometimes it's the person who have offended the gods, so they want to exorcise the bad spirit to come out of the patient. So even in the sun they beat, they whip the patient for that spirit to come out and in the end some of the patients become exhausted and they die. Some become unconscious and by the time that they call for help, the situation is worse.'
(Respondent 1, senior nurse, psychiatric hospital)

Some healers are reported to extort money from their clients or their families:

'The faith healers you know, sometimes end up abusing the people in various forms. They extort a lot of money from them for example. Sometimes there is physical abuse of rights, people are still being chained and beaten because they think that demons are in them, and all of these are all forms of abuses.'
(Respondent 31, senior academic psychologist)

Some respondents felt there should be some form of regulation for traditional and faith healers in order to prevent such abuses:

'The challenge is ensuring that that system is regulated because that is essential. We need to regulate whoever practices any profession. Unfortunately that system has not been well developed, so they go about and do their own things and nobody checks them.'
(Respondent 5, senior academic health researcher)

However one respondent pointed out some of the challenges in regulating traditional medical practitioners, particularly at the level of measuring the efficacy of their treatments:

> *'….officially we have a division at the Ministry of Health level coordinating traditional medical practice. Except that because of the absence of clear guidelines and regulatory frame work its posing a major challenge, I mean because you are trying to integrate orthodox practices with traditional ones.[…..] What is not clearly defined is the scientific basis of some of their claims and other things, and people's unwillingness to subject their claims to that same scientific rigour which is demanded of orthodox medicine.[…..] We believe that they have a role, but I personally believe that the same standards we are applying to orthodox medicine should be applied to traditional medicine.'*
> (Respondent 21, programme director, GHS)

Others more pragmatically suggested education and training for traditional healers in mental health to support them in stopping abusive practices:

> *'….So we need to actually collaborate with them* [traditional healers] *and then help them to be able to actually clean their system so that it can also help the people.'*
> (Respondent 10, programme director, MOH)

3.1.6 Summary

Interviewees situated mental health within the context of current health policy which focuses on the need for health promotion and community-based services which are easily accessible to the majority of the population. Mental health from this perspective was seen as a public health concern and grassroots health education as a means of promoting good mental health. Participants identified those living in rural and northern areas of the country as being the most affected by poverty and the distribution of health services, including mental health services. However mental health was viewed as largely if not completely excluded from the development agenda. Mental health was seen to take low priority in government policy due to the competition for resources in the context of the high burden of physical health concerns in the country, especially malaria and maternal and child mortality. The human rights of the mentally ill were recognised to be severely compromised both within allopathic and spiritual treatment centres. Many respondents recognised the value of traditional and faith healers in the psychosocial and spiritual treatment of

mental illness, advocating greater collaboration between traditional and faith healers and biomedical practice. However, it was noted that some healers abused the rights of their patients and that there was a need for education of healers and closer regulation of their practices.

3.2 Mental Health Situation

3.2.1 Public perception of mental illness

3.2.1.1 Knowledge of mental health

Respondents at the national and regional level expressed the view that there was very limited knowledge about mental health among the general population. Some attributed this to a lack of education. Mental illness was said to be misunderstood and feared:

> *'It is a big problem; the perception of people about mental health is that it is taboo. You know, people look at the mentally ill, the mentally affected with… they look down on them. They are scared of it, they don't understand it. So, mental illness is a misunderstood and difficult area for people in general.'*
> *(Respondent 54, senior academic)*

Respondents reported that for the general public, mental illness is often viewed as a 'spiritual illness' or is connected with drug abuse. This can carry moral connotations as a punishment for misdeeds:

> *'….they view it as a bad illness and something with evil spirits, as something to be avoided as much as possible. You know, sometimes most people don't even view it as part of normal sickness, you know, and as something in response to some bad deeds, as it portrays in the films.'*
> *(Respondent 6, programme director, MOH)*

> *'So with mental illness [.....] .people think either you take in narcotics, or you are into hard drugs or you have done something, and somebody has taken you to juju shrine that is mostly the opinion that people hold.'*
> *(Respondent 27, national newspaper editor)*

3.2.1.2 Concepts of mental illness

Mental illness was associated by respondents at the national and regional level with social isolation, abnormal and antisocial behaviour, dishevelled and dirty dress, nakedness, talking to oneself, and aggression:

> *'Maybe his dress code and everything, I mean, he does not conform to whatever society does. His behaviour, all aspects of his life… if he is not, or he doesn't even want to talk to people, and all that. Always you see him quiet on his own. The man is in a world of his own. So he can't be part of us. So you can easily say that the man is mad.'*
> *(Respondent 22, accountant, psychiatric hospital)*

> *'A normal human being will not talk to himself while he's walking, that is one of the issues. You see some people walking but they talk to themselves. Hallucination, or we say soliloquies, they talk to themselves whilst they walk [….] Some mental illness they don't talk, they walk normal, yet if you look at it from the way they dress, it is very abnormal to see somebody walking with the genital organs open. So if you see some of these things happening, you will realize that this person is out of mind. It is also a characteristic which you can use to determine mental illness. Some of them dress nicely but they go about picking pieces of things that they are not supposed to even pick. This is also a sign, even in the beginning when it is coming these are some of the things that you see. But when it is getting higher, then the person begin to un-wear what he's wearing and walk naked, eat from unclean places and other things. Some also take different dimensions, they attack people, when they see human beings they attack them, that one is very dangerous.'*
> *(Respondent 15, senior officer Mutual Health Insurance Scheme)*

> *'Well, if you see a person, I mean a normal being he dresses nicely, but if you see somebody who dresses shabbily and leave the hair unkempt, and normally you see the person talking to himself, or making some gestures, you would know that there is a problem, there is a mental problem there. If you chat with the person, you may be conversing, but you will realize that the*

attention of the person, or the focus of the issue, is not what the
person is really talking about.'
(Respondent 22, accountant, psychiatric hospital)

'Unguided statements made, you can be considered as mentally
disturbed, disturbing public peace at random can be considered as a
person who is mentally ill…. '
(Respondent 52, trainee counsellor)

3.2.1.3   Causes of mental illness

There was a great deal of consensus among respondents on the perceived causes of mental illness in Ghana. Many stated that mental illness was the result of drug or alcohol abuse, particularly among young men, failed relationships in the case of women, or family hereditary traits. Excessive thinking and 'stress' were also seen to lead to mental illness. As a 'spiritual illness' mental illness could be caused by demonic forces or 'juju'. The following were typical of such responses:

'But this is the use of abusive drugs, narcotic drugs, excessive
alcohol drinking, excessive use of cocaine, excessive use of 'wee'
and all those things. They are creating those things. Aside this,
second is these marriage problems with the females.'
(Respondent 53, biostatistician, regional level)

:

'….maybe somebody being taken to juju, or a shrine for offence
committed. But largely I think it is about these fallen or broken
relationships, peddling in narcotics and maybe heredity matters.'
(Respondent 27, national newspaper editor)

'…the little I know is that, most people think that when someone is
mentally ill, it is juju. Maybe the person has done something wrong
so they have taken him to the juju man. Some also believe that it is
hereditary. So if they see you as a mentally ill person, they say that:
"Eii!! Wei diɛ ɛwo abusia nu mu" [this is in the family] you
understand, and then some also believe that when your pocket is
not correct [you are struggling financially] *you can behave*

abnormally, that is the perception about the people in the community. And some also believe it is drugs, you know, alcoholism and all that, you become addicted and this time the youth go into all those things.'
(Respondent 42, senior health educator)

'Those who are religiously inclined tend to believe that the condition is spiritual. It could be a curse which a family has inherited, or a curse as a result of the person's own behaviors, either insulting somebody or going against the norms of society or breaking a taboo.'
(Respondent 55, senior psychiatric nurse, regional hospital).

Some participants who worked in health care contrasted lay stereotypes of mental illness with the more varied presentation of mental illness. They reported that the association of mental illness in Ghana with madness, abnormal behaviour, loss of function and violence, meant that depression and stress were less well recognised:

'…the lay person sees mental illness as illness caused by madness… The lay person sees mental illness as somebody who is naked in the street roaming about unkempt, or brandishing a knife or cutlass, or something like that, or running into the bush or smoking profusely, this is the concept of a mental patient to them. But this is only a small proportion of the population. Now a lot of people, majority of people, suffer from neurotic conditions, which a lot of people cannot detect except [people like] *you and me. ….the common man on the street does not know the difference, they only know about the one who is roaming on about the street who is mad.'*
(Respondent 56, psychiatrist in private practice)

'…..So if you have problem with your brain it is part of your body, but they see it as something really out of the ordinary and anytime somebody visits the mental hospital they think… say: "You are mad". But there is somebody, some cases that you take there, you know, if you can't sleep, if you have constant headaches and things like that, if you overstress, this does not make you mad.'
(Respondent 51, senior nurse trainer)

> *'When you say somebody is mentally unhealthy, I mean, clearly you are talking about the obvious ones. [......] But knowledge of late, I mean, is telling us that you may find somebody seemingly normal but the person may have some mental deficiencies, okay? Like a depressed person, you could classify as a mental case, but we have obviously thought about the violent ones in the streets and things of that nature.'*
>
> *(Respondent 18, senior academic health researcher)*

3.2.1.4   Women and mental illness

Respondents commonly suggested that the inferior position of women in society, the discrimination against females in work and in family life, and marital breakdown or 'disappointment' in love could contribute to mental illness in women. Some respondents felt that as a result women were more prone to mental illness than men:

> *You see, the women are always in trouble. Even in marriage they are in trouble, in childbirth they are in trouble, in everything they are in trouble, and the men are on top, they are messiahs.'*
>
> *(Respondent 35.3, psychiatric nurse)*

This newspaper editor made an association between broken marriages and mental illness for women, which was repeated by other respondents:

> *'….if you go to the psychiatric hospital in Accra for instance, quite the number of people there, especially the female inmate there, I mean have the problem as result of the broken marriages, fallen relationships and others.'*

Another respondent, a biostatistician at the regional level, thought that as a result of 'marriage problems' women were more frequently admitted to the psychiatric hospitals than men. However statistics available from the hospitals show a more or less equal balance between male and female users of psychiatric services. Those statistics from the mental hospitals which are disaggregated for gender, do show a

greater proportion of males treated for problems associated with substance abuse (see p.108).

However it may be that the true extent of mental disorders among women is underestimated since many of them may not present to psychiatric services. This researcher suggested that women may be more prone to 'hidden' mental disorders such as depression or milder forms of psychosis and so escape attention:

> *'I will say that the obvious mental cases are more common in the men. You see that this can be by way of the cases we see in the streets, do you get what I mean? But I think the ones that are not obvious, the ones that may be hidden like depression, psychosis, at the lower level are commoner in women, okay, and this can be explained due to the male dominance of society and the bias in favour of males. Divorced women may run into crisis and usually it is women that are divorced. So these hidden ones are a big chunk that are not obviously sick but....so if you look at it at that level may be it could tilt even towards more women'*
> *(Respondent 18, senior health researcher)*

3.2.1.5   Treatment

It was stated by some participants that people in Ghana generally believe that mental illness cannot be successfully treated or rehabilitated:

> *'....people feel that, people that are mentally ill cannot be treated which is wrong, that is a wrong perception because they can be treated, and they can be rehabilitated to live normal lives, we just need a collective approach so that we all help to get them out of that situation.'*
> *(Respondent 19, Department of Social Welfare)*

3.2.1.6   Increasing public awareness of mental health

In considering ways to increase awareness of mental health, public health education was seen as an important step, for example through community radio. Respondents suggested education in schools on drug abuse and teenage pregnancy, others

suggested talks to church groups and to chiefs in the communities. However concern was expressed that there were no funds available to launch such campaigns.

One respondent compared mental health with HIV/AIDS and suggested that mental health could draw lessons from the success of campaigns to increase the awareness of HIV/AIDS in Ghana:

> *'To do something about the… The problem about mental health is that, that awareness is not coming out…We seriously as a country, need to do something about mental health, and for me, awareness creation needs to be intensified. I will want to see situations where people take mental health the way that HIV/AIDS propagation* [of information] *is done.'*
> *(Respondent 18, senior health researcher)*

3.2.2 Low priority of mental health

Mental health was perceived by many participants to be of low priority to the Ministry of Health and to society at large. It was felt that there was a lack of interest in and understanding about mental health at the government level. This view was expressed by both policy makers and mental health professionals:

> *'I think the whole issue of mental health is not looked at more critically like they look at maternal health and stuff like that. That is my point; the whole issue of mental health is not an attractive place where people provide money into....'*
> *(Respondent 4, director of department, GHS)*

> *'…. the position of mental health in the social development in Ghana is very low because people are not interested in mental health'*
> *(Respondent 1, senior nurse, psychiatric hospital)*

> *'….people normally say everybody has a little mental problem but unfortunately, it looks like our health policies don't recognize that much, and for which reason we deal with other diseases rather than mental health. And if you could get into our mental hospitals and*

look at the structure, the facilities, the infrastructure itself, and even the number of doctors and nurses that managed those places, then you realize that government policies do not match effectively towards mental health.'
(Respondent 28, criminal justice)

Policy makers agreed that there is a large unmet need in mental health. Concerns expressed by respondents included limited human resources, an inadequate budget, poorly resourced and congested psychiatric hospitals, the inadequate supply of psychotropic drugs, the problems of accessibility to psychiatric facilities for people in the central and northern parts of the country, and the presence of mentally ill vagrants. A senior policy maker at the Ministry of Health captured the gap between the mental health needs of the country, and the availability of mental health services:

'…..we have not been able to fulfil the totality of the mental health needs in the country. Our psychiatrists are aging, we have very few of them out there, our mental health nurses are not enough, access to mental health services in places like Savelugu that are far from Accra and Kumasi and things like that is limited. People don't have….there is no universal access to mental health services. There are too many mental health….people are mentally ill walking on the streets that we have not been able to respond to their needs. I mean generally, access to services, we have a problem, knowledge about how to have good mental health is very limited in our society.'
(Respondent 6, director of department, MOH)

Mental health professionals were unanimous about the low priority given to mental health in terms of treatment facilities and resources, support from other health disciplines, and even in the supply of essential medication:

Interviewer: '….is mental health in the development agenda in this country at all?'
Respondent: 'On paper, yes, I have no doubt in my mind that it is, but in practice I don't think so. Look at the situation in our mental health hospitals. The facilities are running down, there is shortage of nurses. Even though there is shortage everywhere we are worse off than anybody else. The way the Accra mental health hospital is run

down even, they wouldn't treat any other hospital like that.[.....] When you look at the resources that go into mental health, I don't know about elsewhere, but this teaching hospital, we literally have to beg to be given what in my view represent the minimum requirements for us to work. We were treated that way by the administration. We have only one doctor and the work load here is heavy. The pharmacist, we have to beg them literally for them to look at you in the face. Most of our drugs come and they stay there, expire without them informing us. We will run short of drugs and they will not be replenished unless we go to beg. As I speak now can you imagine such a thing as chlorpromazine is in short of...? We run out of chlorpromazine. How can you run a teaching hospital like centre of excellence when we lack such a basic thing like chlorpromazine?'
(Respondent 54, senior academic)

'If you go to the medical stores to get your drugs those who have money and they have paid for the drugs they will serve them and they will not serve us. And even sometimes we don't get our drugs, as you are interviewing me now, since January this year we don't have any Tegretol in the system. And here we are, we use this Tegretol for most of our patients and we don't have, and some of these are drugs when you go to the pharmacist shop, it is not drugs that are common. You can't get it so what do you expect from our patients? They will relapse and they will come back to us.'
(Respondent 1, senior psychiatric nurse, psychiatric hospital)

There was a suggestion for greater advocacy for mental health in order to increase the priority of mental health in Ghana:

'I think we need... we need a strong advocate or advocates for mental health in this country, I really do. We need a group or individuals that will able to speak up on behalf of mental health because in African society, mental health has been shunned. It is something that is behind the scene, and they need a voice, they need to hear..., people need help in the mental arena.....I think we

need an advocate or advocates to bring mental health to the
forefront.'
(Respondent 37, clinical psychologist)

3.2.3 Poverty and mental health

Respondents recognised a clear link between poverty and mental health. Deprivation was seen to lead to excessive worrying which could in turn result in mental disorder:

'…..it's quite obvious, if you are poor you can't get three square meals to eat, you can't look after your children, you tend to think more, you tend to get more worried and one of the causes of mental illness is excessive worrying, when you can't find your way around problems, you will get a mental break down, those are things that will cause stresses. You pass through all these stresses and along the line you breakdown. So we think there is a very strong link between poverty and mental illness'
(Respondent 45, medical doctor, psychiatric hospital)

'…..somebody who is very poor and is thinking about his daily bread and his inability to fend for himself, take care of himself or the family, and is not able to come out of that situation, sometimes thinking about the problems can also sometime even make people become mentally sick.'
(Respondent 17, policy maker, Ministry of Manpower, Youth and Employment)

Older people were also seen to be vulnerable to poverty and mental illness:

'…. poverty is also a contributing factor, especially the aged ones. You know, the old ones who have nobody to care for them end up on the streets begging and before that they don't take their bath, they don't comb their hair, then they exhibit signs and symptoms of mental problem, but deep down if you go there you find out that the bottom line is poverty.'
(Respondent 51, senior nurse educator, regional level)

Others also acknowledged that mental illness itself could lead someone into poverty, through impairing the person's ability to work productively:

> 'If you are mentally retarded in the first place you can lose your job and that has something to do with poverty. Your family can be poor because you are not working and besides that, on the part of production, if it is on the part of farming, you won't be able to contribute your quota effectively to the family and that can cause a lot of harm to the family.'
> (Respondent 52, trainee counsellor)

Some respondents linked the use of drugs and alcohol and the consequent mental health problems to poverty, suggesting that poverty could lead to drug and alcohol abuse as an attempt to cope with the situation:

> '...the rich man, he who has, he manages himself, you know, no one would just get money, be blessed and have money and resolve to drinking and all those things. But it is those who don't have mostly, because the thinking is about: "When I get buzzed [drunk] I forget about the problem" So mostly they even go and borrow it, you see, forgetting that when they become sober the problem comes back.'
> (Respondent 22, accountant, psychiatric hospital)

> '….if somebody is poor and doesn't get enough resources to take care of his family okay? Unless the children grow, they require some basic needs: food, shelter, clothing and that kind of thing. So they would try as much as possible to even struggle themselves and sometimes these young ones fall into bad company and because their parents have not [been] able to put them under their roof and have control over them, educate them through school, you know, talk to them, socialize them and advise them, they go into these bad groups….company, and then they begin to engage themselves…especially when they get into contact with drug-smoking and all those things. Sometimes these things expose them to or make them more susceptible to becoming mentally deranged. So that is where for me poverty comes in.'

It was felt that the low priority of mental health meant that the poor and mentally ill remain neglected in government policy:

> *'When you are poor and you unfortunately run into mental health problems then you are dead, you are a carcass, because nobody is going to mind you….So mental health and poverty is still far down the ladder and I think something seriously needs to be done.'*
> *(Respondent 18, senior health researcher)*

Education was seen as one way of lifting people out of poverty and back to work. Respondents also stated that mental health policies should address poverty, since reducing poverty was a way of addressing the mental health consequences:

> *Interviewer: '….do mental health policies address wider societal issues like poverty, stigma and others?'*
> *Respondent: 'Yes, it should address that because when you get out of these things then poverty will be reduced, you see, it's a vicious circle, poverty can bring about the mental ill health, mental ill health will also bring about poverty, you know, so if you break the chain somewhere then...'*
> *(Respondent 41, regional director, GHS)*

3.2.4 Stigma in mental health

3.2.4.1 Stigma towards mental illness

Many respondents identified pervasive stigma towards those with mental health problems in Ghana. This lead to mental illness being a hidden problem:

> *'….there is a whole lot of discrimination and stigma and that is a big, big problem in the sense that, if I am mentally ill, I may not tell you that I am mentally ill. I am happy to tell you I have BP* [high blood pressure] *and so you shouldn't be talking too much because my BP will rise [……] But to let people know that: "Well, I suffer epilepsy so*

when you see it this way, please help me." Very, very few people would want to own up in that sense. And so ....the issue is more or less swept under carpet and the rest, and that is why you see lots of them locked away in rooms or chained because of the extreme stigma. And that is a serious problem with regard to understanding mental health or mental health problem confronting us as a nation.'
(Respondent 57, director, mental health NGO)

Stigma was related to a perception of mental illness as being predominantly associated with 'madness' and aggression:

'The perception is that people with mental diseases can be aggressive and therefore there is a tendency to avoid them just in case they became aggressive. But I guess it is also because people don't understand all the issues within the mental health arena, even health workers are very sceptical about getting into mental health..'
(Respondent 5, senior academic health researcher)

Other respondents suggested that the association of mental illness with spiritual causes, such as witchcraft or demons, a curse, or some form of spiritual punishment, could also result in stigma:

'.....but as soon as you have mental problem, because for that one they think of demons, then all sorts of facts that probably the person who has the problem might be aggressive, so even our staff, even doctors, are afraid of mental patients, you understand, because they think they can attack. Also the fact that they have these demonic ideas about them nobody wants to go near them.'
(Respondent 38, psychiatric specialist)

However, there were indications that attitudes could vary depending upon the perceived aetiology of the illness. Thus if a genetic factor or a life event resulted in a person developing a mental illness they were more likely to receive public sympathy than somebody who became mentally ill as a result of the abuse of narcotic drugs. Some respondents distinguished between mental illness which was 'health-related' and that which was 'self-inflicted', such as drug or alcohol abuse:

Interviewer: 'Now what's your opinion on mental illness? We have looked at the society's opinion so I would want to know your own opinion?'

Respondent: 'I also have the same attitude because it is attitudinal; I mean it depends on how you get your mental condition, if it is a health related mental condition that you have not self-inflicted something on you by drinking hard drugs or something, I mean there is the tendency to be more sympathetic and commit money to it and ensure that you regain your health. But if you are a habitual drug addict and it ends in that and the family tries a couple of times to rehabilitate you and you still go back, there is the tendency of people giving up and leaving you to your own fate.'

(Respondent 23, legal practitioner, judicial service)

Several respondents indicated that the psychiatric hospitals are themselves a source of stigma:

'There are some places the stigma is there… remains… so that even if you come…. once you have gone to the….once you have seen the inside walls of the mental hospital, and you come back, I mean nothing about you is correct.....'

(Respondent 84.6, teacher, focus group discussion, district level)

'….when you come into the hospital, you lose your freedom as a normal person. You are a mental patient that is, it takes a very long time for a non-mental patient to be able to convince the health personnel that he is not a mental patient'

(Respondent 7, pharmacist, psychiatric hospital)

One user revealed his experience of stigmatizing behaviour from staff working within the psychiatric hospitals:

'It is my hope that they will assist me out of this problem but now I'm not in good terms with them. Sometimes they make mockery of me with the sickness. Now I have made my mind to go home because I have seen that they want to take me to the ward where those who

are naked are living. When that happens, I will be destroyed so I will
go home and even if it is outside, I will sleep.'
(Respondent 77, user of psychiatric services)

Whilst this view could be dismissed as merely reflective of the patient's lack of insight, or of symptoms of paranoia, it is illustrative of the poor conditions of the psychiatric hospitals which is in itself stigmatising through its impact on the dignity of the patients.

3.2.4.2 Consequences of stigma

Stigma has several consequences for those with mental health problems and their families. It may prevent people from seeking help:

'People who are mentally ill are stigmatized, so most people
wouldn't even come out to seek the necessary help that they need
and to even take treatment which is available. And so people suffer
for nothing and especially children with epilepsy and things.'
(Respondent 16, World Health Organization, national level)

The fear of stigma could lead to the family abandoning the person:

'People see mentally ill patients as non-approachable, you know,
you can't approach them, they are harmful and they don't want to
get near them. More so if a relative or somebody exhibits those
characteristics. They are likely to abandon that person for fear of
being stigmatized. So that mental health is not seen as a disease
that one should associate him or herself with.'
(Respondent 43, senior nurse educator)

'Well, when it happens so, from the family perspective, in the
beginning there is that anxiety, they really want to get cure for the
person. So in the beginning, that desire, the urge is there, they
rush the person to the hospital or to other places that they think
they can get cure for the person, but as time goes on, if the cure is
not coming, I mean, maybe it is not coming well, then they give up
and they don't see any good in the person again, and that is why
they even abandon the person altogether either at the hospital or

wherever that they send the person to, and the person therefore is considered an outcast, you see, that is where that stigma is. So they really don't feel, I mean in terms of family, they don't even want the person to come back into the family because they feel it's going to be a disgrace to them, you know, in some places when there is quarrel they begins to insult that: "You, your family, you're mad people, that madness is in your family", and those things, so society then also frowns on such people they normally don't want them back.'
(Respondent 22, accountant, psychiatric hospital)

The stigma associated with mental illness also results in discrimination against those with mental illness in terms of opportunities for employment:

'…when somebody is not mentally sound, no employer would want to take such a person to work for him or her because it will mean that you would not be productive as it should be… I mean, as it is expected. So no employer would like to employ somebody who is not sound in the mind.'
(Respondent 29, counsellor)

'Employers per se, let me say that, I don't think there is any employer who would like to give employment to a person like that, and if the person is already in the employment and it happens then of course it's already there. If it happens and the person is rush to the hospital in good time and have the treatments and is a little bit ok, well the employer has no problem because the person is going about his normal duty. I mean once the employer has no problem with the person I don't think that there is a problem there, but where the person goes back and can't perform, then of course the employer also pursue that: "You know, I cannot continue working with a mental person, I mean somebody who have mental problem", and so of course you also have to get the person out of his employment.'
(Respondent 22, accountant, psychiatric hospital)

3.2.4.3 Stigma towards mental health professionals

The stigma towards mental health was reported by many respondents to extend to health professionals working in psychiatry and to the specialisation as a whole:

> *'It is a fact also that when you come to psychiatry, be you a doctor or a nurse, there is a big stigma attached to you. People also use you as the butt of their jokes'*
> *(Respondent 55, senior psychiatric nurse, regional level)*

> *'Even when you go to the market and they know that you are mental health nurse when you talk 'abodamfoɔ'* [mad person]*, because we are there, it transfers to us. Sometimes they insult us, even the general side people* [general nurses]*, they insult us.'*
> *(Respondent 35.3, psychiatric nurse)*

> *'Even the stigma, people sometimes when they see that you are working with the mental health and you stay there, whenever there is something and perhaps you say, they will say: "Oh that guy don't mind him, he is with mental health so he is behaving like them.'*
> *(Respondent 35, health administrator, regional level)*

Respondents suggested that the stigma, together with a fear of the patients as 'dangerous', means it is difficult to recruit health professionals into psychiatry:

> *'….nobody wants to be trained for psychiatry because of this stigma and then they say that there is no motivation. Do you understand? They think that is dangerous and there is no motivation, it's a dirty job, why should I go there?'*
> *(Respondent 38, psychiatric specialist, regional level)*

The stigma was seen to work even at the highest political levels, meaning that psychiatry was often overlooked in policy formulation and implementation:

> *'People just don't want to join the psychiatric unit because of the stigma that is attached to it. We have to work a lot on stigmatization; even stigmatization comes from educated people, from our own*

colleagues, even the director general inadvertently, unconsciously, stigmatizes psychiatry by forgetting that we exist. They sometimes even forget that we exist. Certain letters that should come down to invite us to certain places, sometimes they remember us as an afterthought from very high places. Politicians, they forget us. I remember a prominent politician I was sitting down with sometime ago, we were discussing an issue then I decided to slot in psychiatry, he just look at me, smiled and said: "When we are thinking of people who would vote for us, you are thinking of the psychiatric patient who doesn't have vote." This is the type of stigmatization that people have, and they stigmatized everybody, not only the patient, the whole unit.'
(Respondent 7, pharmacist, psychiatric hospital)

Interviewer: Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people?
Respondent: For now, I think it's no. Because, if you look at the way those with mental conditions are handled, even family members tend to run away from relatives who are seen to be suffering from certain conditions and it looks like the support for such group is very little from central government. They only talk sometimes about these things, but we see very little action.'
(Respondent 59, health manager, district level)

Consequently the stigma attached to mental health was reported to affect the prioritising and funding of mental health care.

'Most of our patients are stigmatized and that even affects the allocation of funds because people don't see how money that should be given to people who are sane to be given to the insane who they feel can not contribute to society.'
(Respondent 26, senior psychiatrist)

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3.2.4.4 How to address stigma

Several respondents mentioned education as a means of addressing stigma towards mental health:

> *'….they should educate the people to get away from that stigma and then people can walk straight into the psychiatric hospitals and then come out with their problems.'*
> *(Respondent 51, senior nurse educator, regional level)*

> *'Education must start somewhere, you know, educating people to understand that if somebody is mentally ill, it doesn't mean the person should be avoided or something. And, like I said, that education must start somewhere, having mental health education incorporated into our curriculum so that it would be taught in our basic schools.'*
> *(Respondent 27, national newspaper editor)*

One respondent suggested that mental health professionals could themselves take a role in developing a positive profile for mental health in Ghana:

> *'There is the need for people to understand what mental health is all about and change their attitude about mental health. There is the need for them to talk positively about mental health and there is the need for us who are in the mental health to carry ourselves in such a way that people realize how important our work is.'*
> *(Respondent 54, senior academic, regional level)*

3.2.5 Participation of mental health service users in policy formulation

Respondents differed in their opinions as to whether users of mental health services should be involved in policy formulation.

It was acknowledged by some that for a policy to be sound, it needs the participation of those affected. This participant at the ministerial level gave as an example the involvement of people with disabilities in formulating the disability policy:

'…people with disability were involved in formulating that policy, it is their law, it is what they want that can make their life better and easier, so we called them to be involved. In the same vein, if it is the police or the prisons or whatever they want to put something like policy, the people themselves, the views of the prisons given in there should be very, very crucial, should be important when you want to make a good policy because those that are affected should have a say.'
(Respondent 19, programme director)

However when it came to the question as to whether those who are affected by mental health problems should be involved in policy formulation, some respondents, such as these teachers from the district level, expressed scepticism about the contribution that those with mental illness might be able to make:

'Before you can make a…..contribute to the policy making of the whole, it means you have to get at least a sound mind, and somebody with this mental illness cannot reason properly to give out good information, good suggestions for the entire nation. So I don't think they are needed.'
(Respondent 83.2, teacher, focus group discussion, district level)

'….I don't think they [people with mental illness] *should be involved* [with policy formulation] *because somebody who is mentally affected cannot bring normal policy for the benefit of the whole nation.'*
(Respondent 82.1, teacher, focus group discussion, district level)

However such responses were not restricted to non-health professionals. One medical doctor saw the suggestion of involving mental health service users in the development of policy as implying that mental health policy is being given less importance:

'The policy makers must look at it as very important area rather than asking for those in the mental health problem to come in forming policies.'

(Respondent 74, medical doctor, district level)

However other respondents among both health professionals and non-health professionals felt that since most people with mental disorders are not chronically ill they should be allowed to take part in the formulation of policy when they are recovered:

> *'Maybe those who have been rehabilitated, they have come back to normal life, I am sure from their experiences, if they remember, they will be able to influence policy direction.'*
> *(Respondent 59, health manager, district level)*

> '*There are cases where mental patients have been fully treated, they are fully recovered and for the rest of their lives they have lived normal life. So* [for] *such ones there is nothing wrong involving them in policy making as regards to the workplace and other place.'*
> *(Respondent 83.4, teacher, focus group discussion, district level)*

Some suggested that as 'experience is the best teacher', those who had experienced mental illness themselves would make valuable contributions towards developing policies which concerned those facing the same or similar difficulties:

> '*I think* [for] *some of them it depends on the type of mental problem. It is better for you to let the person who has) experienced the thing to come out. An example of somebody who has AIDS or somebody who has been in a little marital problem or something before, to me when the person is out of the thing, I think it is better for the person to come and sit down to explain a little about it. So in some aspects, I think those who have passed through a little should be invited'*
> *(Respondent 83.1, teacher, focus group discussion, district level)*

> '….the patients themselves, because they have ever been in such a condition, they are the best people to advise people on what happens and the dos and don'ts so that others do not fall into such mental health problems.'*
> *(Respondent 69, deputy headmaster, district level)*

> *'Everybody has an opinion about something and as a matter of fact,
> if those at the grassroots are to partake in such policies, I believe
> sincerely we would come out with strong and concrete policies and
> surprisingly you may even see mental people bringing out very
> intelligent opinions about how to make policies very strong. Though
> they are mentally disturbed, sometimes they are very intelligent.
> Sometimes as I said it is out of the problem they have encountered,
> out of it they have mental stress that leads to mental illness. But that
> doesn't mean they are very stupid.'*
> *(Respondent 52, trainee counselor, district level)*

However this respondent from the Ministry of Health felt that although people directly affected by mental health policies, such as users and their carers should be consulted in policy formulation, they were often excluded due to stigma, poverty and a lack of awareness of current policy:

> *'First they even don't know where the policy is being developed and
> they will not normally agitate, you know, for their rights or so. They
> are taken for granted because of poverty, because of circulation,
> vulnerability, you know and stigma.'*
> *(Respondent 6, Programme Director, MOH)*

3.2.6 Summary

Responses indicated a perception among policy makers, professionals in health care and the allied professions of a lack of knowledge and awareness of mental health amongst the population. Mental illness was reported to be viewed by many Ghanaians as a spiritual illness associated with punishment for immoral behaviour. Mental illness was seen to manifest itself in abnormal or antisocial behaviour, including aggression. The causes of mental illness were linked to gender by several respondents. For men, mental illness was perceived to be the result of drug abuse, for women, mental illness was linked to failed relationships and their perceived inferior position in society. The association of mental illness with aggressive behaviour, drug abuse and madness, means that common mental illnesses such as depression may be overlooked. Public health education at the community level was seen as important in raising awareness of mental health.

Participants widely agreed that mental health is a low priority in Ghana resulting in a gap between the needs of those with mental illness and the services available. Mental illness is seen to be overlooked in funding allocation and facilities neglected and poorly maintained. Consequently resources are inadequate to provide effective mental healthcare with a scarcity of health professionals and facilities, as well as effective treatments.

Poverty was seen to be strongly associated with mental illness as it could lead to excessive worrying, which could in turn lead to mental illness. It was acknowledged that mental illness could itself lead the person into poverty through reducing productivity in work and daily life. Poverty was also associated with the use of drugs and alcohol. The association of mental illness and poverty leads to a double burden for the person and their family. Addressing poverty was seen to have the potential to break the cycle of poverty and mental illness.

Respondents identified pervasive stigma towards those with mental illness. Stigma was seen to arise as a result of the association of mental illness with madness and aggression, and the view of mental illness as a consequence of spiritual punishment or malign spiritual forces such as witchcraft and demons. Stigma has serious consequences for those with mental illness preventing some from seeking help. Some are hidden from public view or abandoned by their families. People with mental illness suffer widespread discrimination, particularly in employment. Stigma also extends towards mental health services such as the psychiatric hospitals and towards professionals who work in mental health. This affects the morale of staff members and the recruitment of health professionals into psychiatry. Stigma towards mental illness also affects the prioritising and funding of mental health services with mental health seen to be overlooked in policy formulation. Public education was seen as the key to addressing stigma in mental health.

There were differences expressed among participants as to whether users of mental health services should be involved in policy formulation, with some expressing the view that users would not be able to make a valuable contribution. Others felt that as the recipients of services, those with mental illness should be consulted in policy formulation for mental health and that the experiences of users would be of benefit in formulating effective policy. However in practice it was felt that those with mental illness were seldom consulted due to pervasive stigma and their generally low social status.

3.3 General Policy Making Processes in Ghana

Most policy makers indicated that ideally policy-making should be a bottom-up process that emanates from consultation with key stakeholders at the grassroots. Following the consultation, a draft policy is compiled. This is then debated in parliament, following which a white paper is drawn up, before being accepted for implementation.

> *'Policy making in Ghana for instance should come from the grassroots that is how it should be. We have members of parliament who sit to enact…, so before they take any policy out, they are supposed to make sensitization, they go down to the grassroots and get the opinion and views of the people…. then when these views are collated, the various members of parliament send it to parliament for a debate. Then government will adopt it, write the white paper on it and then it is implemented.'*
> *(Respondent 15, senior office, Mutual Health Insurance Scheme)*

> *'But basically the Ministry of Health level is the policy making body and depending on the issue involved, it involves consulting people from the grassroots, getting feedback on a particular issue and then through various stakeholder discussions, we come to a consensus on that… It moves into…. the dissemination of that consensus agreement for various people to give feedback to that, and then after passing through a series of further consultations, finally the minister appends his signature to the document, it is then circulated to various stakeholders, I mean, for implementation.'*
> *(Respondent 12, programme director, GHS)*

Stakeholders in the health sector identified by respondents included health professionals, donors, NGOs, church leaders, traditional authorities, district assemblies, as well as users of health care services and their families. Also mentioned were other related ministries and agencies such those who deal with water and sanitation.

This respondent described policy-making in Ghana as a 'process' or 'dialogue' which involved consultation with a wide variety of stakeholders, from the users of health services up to government level:

> *'….policy formulation is a process, it is not a one time event and there are various stakeholders in the health care delivery environment.[....] The health sector as you know, is decentralized: we have the headquarters, we have the regional, district, sub-district people, and these issues percolate from down there where the needs of the people are identified by the community members and the sub-district people identify what these needs are and it goes up to the district level, to the regional level before it is crystallized at our national level. So it is a dialogue that is continuous.'*
> *(Respondent 5, senior academic health researcher)*

However, the responses of policy makers indicated a gap between the textbook process of policy making and the reality on the ground:

> *'…. people think policy is about classroom work. In reality, it is not. So there is not…I mean there is supposed to be a laid- down process, but in reality it doesn't happen. I don't want to go into the theoretical processes of policy making. But basically, we would want to bring up a policy to address a need. A need can be defined technically, can be defined politically, or you can define it from numerous perspectives. So it can be brought on to the agenda by the media. But generally, you will put in place a certain policy intervention to address a specific challenge and that can be based on analysis of a certain urgency and immediacy. Ideally, you should do all the analytical work. In reality, it does not always work. Ideally it should go through a certain process in terms of steps and in terms of consultations that ends at the cabinet level. Sometimes it moves from policy to legislation, to the legislature but this doesn't always happen.'*
> *(Respondent 6, director of department, MOH)*

This was borne out by the responses of interviewees working within health services who stated that in practice extensive consultation did not take place at the grassroots level:

> *'Yes those that we think they are under-representing is the community members, talking about the District Assemblies, the local government, the religious bodies, all these people should be part of it, but they are not. It is always done at the top there, the ministerial level. Then they call us, we the professionals to make input. So we just go there to develop standards, protocols, procedures, but at the end of the day the stakeholder is at the community, the district assembly, the religious bodies and the NGOs should be represented.'*
> *(Respondent 47, hospital administrator)*

It also became clear from the interviews that sometimes policy is driven by processes other than the needs of stakeholders. This researcher claimed that government manifestoes may play an important part in driving policy formulation:

> *'….the government also has a development agenda which includes health, so the President can say: "Well I think this is an area in health that I need to address", so apart from the policies being emanated from below, government can also decide that, for instance, I mean, they decide as their…….. So, yes, government can have its policy directions that: "This is what I want to do".….'*
> *(Respondent 5, senior academic health researcher)*

Moreover respondents noted that international health partners and donors have a significant influence on health care policy. Some policy makers stated that external agencies such as WHO, the World Bank, UNICEF and DFID, provide the majority of funding for the health budget in Ghana. According to the Ministry of Health, the percentage of earmarked donor funding for health ranged from 60% in 2001 to 40% in 2006, representing a significant proportion of the total health budget (Ministry of Health Ghana 2005). It was observed that the consequences of this external investment in Ghana's health budget were that the funding priorities of NGOs and other external stakeholders could determine what needs were addressed in health planning:

'….whether you like it or not, if you have a budget, a country's budget that depends almost 60% on donations from outside the country, then the donors also have a role. So all of them come on board. I mean maybe DANIDA say: "I have money to do this", maybe USAID also say: "Maybe as for me I don't want my money to be used for family planning", maybe…. I mean they all have their interest. So you need to take all those all those on board, and then we have the NGOs, small NGOs, also doing their own things in their corners and all that.'
(Respondent 5, senior academic researcher)

Policy makers stressed that policy decisions in health in Ghana are not made unilaterally, but are driven by global trends and international agreements to which Ghana is a signatory. For example, organisations such as WHO and the UN agencies have global targets, such as the Millennium Development Goals and policies are formulated at the government level to facilitate the achievement of such goals without going through the process of stakeholder consultation:

'There are some global…..serious global issues that will continue to influence the way we do business as a country. Millennium Development Goals stand out quite strongly, currently providing a new focus for the way or for the results we all want to achieve. Whereas in the health sector, there are things like the global funds that have come to stay. Aiming at pushing forward the TB, HIV/AIDS. There is a whole area of globalization and WTO activities that is influencing international property rights issues as they relate to drugs, there are things to do with something called a Paris declaration that is about aid effectiveness, harmonization, alignment of support. Global economic trends affect us in health and the recent increases in fuel affected the health sector, terror is leading to changes in the way you do business…..everything affects everything here.'
(Respondent 6, director of department, MOH)

'….. there are global strategies, global policies that look at all these and then see how we can work towards achieving those goals and

> *policies. If you take the World Health Assembly for instance, it is all the health ministers who meet and then they decide the way forward. So if the heads of agencies and the AU decide that this is the way forward, then it comes to government. It is up to government,… how best they can align their policies and strategies to attain most of these goals.'*
> *(Respondent 11, World Health Organization)*

One respondent compared the difficulties of working with the ideological priorities of the various funding partners to 'walking a tightrope', in which it was easy for certain issues to become defused:

> *'Most of our decisions are determined by the resources that are put up at our disposal. We have to play a game with different partners who have different ideas and ideologies and so it is a very difficult situation. Having said that, I would like to emphasize the fact that, priorities in the health sector and funding priorities in the health sector is a very difficult issue, but it's like walking a tightrope….'*
> *(Respondent 21, programme director, MOH)*

Another respondent indicated that it is sometimes those policies which do not pass through the process of grassroots consultation that are most easily implemented because they come with strong government support and resources. He gave an example of the National Health Insurance Scheme:

> *'....this government in power now have decided that out of their manifesto they want to abolish 'cash and carry'. So as far as health financing is concerned, that is their position. But then if they say they want to abolish 'cash and carry' who pays for the services? So then through that declaration the technical people are mandated to work out an alternative health financing mechanism and history tells us what has happened.'*
> *(Respondent 5, senior health researcher)*

Concern was expressed by several respondents abut the gap between policy and implementation. One respondent pointed out the need to ensure that the resources are available to implement the policy in the first place:

'…you make sure that even if that policy that you are going to put in place is implementable. That is the important thing: Are you going to get the desired results by putting the policy in place? That is the question you should ask yourself, and of course you don't just formulate policies for the sake of formulating. You want to change a particular situation from the worse to the better, that is why you even formulate policies and put the structures in place, put the strategies in place in getting in back.'
(Respondent 19, Department of Social Welfare)

3.3.1 Summary

Responses identify a gap between the ideology of policy-making in which there is extensive consultation prior to policy formulation, and the reality of policy-making in practice. Participants suggested there is little consultation with stakeholders at the community level and that policy in Ghana may be driven less by grassroots consultation than by the priorities of government and donor agencies. Global development policy sets targets and agreements which often drive the formulation of policy at the national level in Ghana. Policy can therefore become concentrated in key areas defined at the international level. Respondents expressed concern about the commitment to policy implementation and suggested that it is often those policies which originate from government and donors which are provided with the most support and resources for their implementation.

3.4 Process of Mental Health Policy and Law Development

Much of this and the following section draws on results from the completion of the WHO Mental Health Legislation and Policy and Planning Checklists. The full text of the completed versions of these can be viewed in Appendix 2.

3.4.1 Mental health policy development

Respondents indicated that the development of mental health policy and legislation is also seen as a process that starts with consultation with relevant stakeholders. However it was acknowledged by this psychiatrist that consultation rarely reached down to those stakeholders at the grassroots of mental health service provision:

> *'Mostly, it is only mental health providers who are involved in the development of the policies and we involve heads of the units but it doesn't transfer to the whole other non-mental health providers. It is more within the…. it is more like a vertical consultation more than involving all the other stakeholders. But then this is usually corrected by the meetings that we have with the management. We have management meetings which used to be twice a year. It is then that we explain some of the policies to management. But that doesn't go down to the implementers at the lower levels.'*
> *(Respondent 26, senior psychiatrist)*

Mental health professionals talked about the lack of consultation in policy development, particularly in the rural areas, far from the centres of power. Some perceived policy-making in mental health to be a hierarchical process which excluded those at the grassroots, such as less senior health professionals, and traditional or faith healers:

> *'What happens is, if let's say policy is to be drawn on psychiatry, yes we know the doctors are there, we know the nurses are there, yes, usually you will think in terms of the specialist, we think in terms of nurses who are in charge, the PNOs* [Principal Nursing Officers]*, the directors, but then at times, that nurse who is not a director but is in a typical rural area representing the government as regard to*

psychiatric services, that nurse has got some information. She knows some solutions or some problems which if they were presented to this body, will be able to achieve and redraw or refocus their vision. But then these people are ignored for all… before they hear [about it]*, some people have met in Accra and this is what they are going to do. So they say: "Okay, let them go ahead". So if the thing starts, for example, a letter is sent to this people, that: This is what we are planning to do. What do you think?*
(Respondent 55, senior psychiatric nurse, regional hospital)

This respondent thus is suggesting that it would be difficult for implementers to accept new policies when they have not been consulted from the outset.

'Now when these things are happening, I mean nobody rise to stand and say: "No, we are all talking about this, but have you considered this area? Have you asked this man? This man is knowledgeable, this man is in the community, even it could be those people who have been treating our patients in church houses, let's go and ask them why the people come there in the first place? If we know why, yes some of them will prefer going to the fetish priest. Why do they go there?" You can still ask them, they can also give a contribution. But then we always think that these are experts - the specialist, the administrators, but these people are always in the cities. Life in the cities and the philosophy when you live in the city is usually different from what is pertaining in the rural area..'
(Respondent 55, senior psychiatric nurse, regional hospital)

One psychiatric nurse pointed out that if mental health professionals are involved in developing a policy, then they will be more likely to be committed to implementing it:

'... but when it comes to policy making sometimes, they make the policies and they push it onto us. We are not part of the policy…..It's not broadened. Even sometimes we are not aware of it, and before we realise: "This policy has been made and this is your copy". Then how do you implement it? Because when you are part of the planning you make sure for the policy to succeed, you make sure you implement it very well.'

Another respondent felt that due to the low priority of mental health, the formulation of mental health policy was always an 'afterthought':

'I will tell you the truth: the attempt to formulate policy for mental health is always an afterthought in my view, it is not the priority in itself. Now when something is not a priority, we don't give a whole lot of attention to it. We are not even attentive to the processes that will affect the best policy for you. So, that I believe is the reason why mental health is not given the priority attention and therefore it is always an afterthought.'

(Respondent 19, department of Social Welfare, national level)

3.4.2 Current status of mental health policy in Ghana

Completion of the WHO Policy checklist revealed that the 1994 Mental Health Policy had a high level mandate for its development as the Director General and the Chief Psychiatrist as advisors to the Minister of Health were involved in the policy formulation process. Consultation took place with the Medical Directors of the psychiatric hospitals, the Department of Policy, Planning, Monitoring and Evaluation at the Ministry of Health and the Health Research Directorate. However there was no budget allocated to the policy development process. There was no consultation with representatives from the health sector responsible for pharmaceuticals, human resource development, child health, HIV/AIDS, and epidemic and disaster preparedness divisions. There was no intersectoral consultation with representatives from the Ministries of Finance, Education, Social Welfare and Criminal Justice. Users of mental health services and their families were also not consulted in the development of the policy, nor was the private sector. There was little international consultation, although there was some exchange of information with Nigeria. The main sources of data to inform the policy development were student theses and quality assurance data from the psychiatric hospitals. No research was undertaken to inform the policy, and there was no consultation with the Health Research Centres of the Ministry of Health.

The policy promotes the development of community care and the integration of mental health into primary health care. This was confirmed by participants in the qualitative interviews who stated that current mental health policy prioritises moving the focus of mental health care away from the psychiatric hospitals and towards the integration of mental health into general medical hospitals in the regions and primary care clinics:

> *'The priority is we want to establish a psychiatric wing at all the tertiary institutions like Korle Bu Teaching Hospital, Komfo Anokye Teaching Hospital and the regional hospitals in the whole place. Then when you come down to the health centres and health posts, anybody with even a psychological problem, we want that person to go to the health post, nearer… accessibility… nearer to his home or his village…..'*
> *(Respondent 1, senior psychiatric nurse)*

In addition the mental health policy also addresses the shortage of staff in mental health through the training of additional staff and the provision of incentives to enable the retention of staff in mental health services.

However an important omission in the mental health policy is the source of funding to implement many of the policy objectives.

The only specific group targeted by the mental health policy are those affected by substance abuse.

3.4.3 Areas of action for policy development

The WHO policy checklist and interviews with participants revealed several areas for policy development. Participants expressed the need for mental health policy development in Ghana, with several participants stressing the need to update current mental health policy. It was suggested by some participants that mental health policy development was of importance since mental illness was perceived to be becoming more widespread in Ghana and hence a public health concern:

> *'…mental health has not been given the needed support in the country, we have not treated it as an important area in our health delivery and I think is about time we become very serious in that. Because the conditions…, mental illnesses are now becoming very frequent, they are becoming common; there is a public health concern. So we must develop polices to be able to change the trend, the terrain and the development of mental health.'*
> *(Respondent 74, medical doctor, district level)*

Furthermore, it was recognised that mental health policy will need to be modified in the light of the new mental health legislation, so that laws and policies will be working 'hand in hand'. It was suggested that mental health policy would be given more power by making it into law:

> *'There are so many policies that even our policy I don't think has been, so to speak, well, I think it is approved, but it has not gone through parliament. The policies were approved at the ministry level, they were not policies backed by law. So it's more like a gentleman's policy which from time to time we tease out some and implement.'*
> *(Respondent 26, senior psychiatrist)*

The WHO checklist revealed the need for more extensive consultation in the development of mental health policy, particularly with users of mental health services and their families and other community-level stakeholders. This was echoed by respondents in the qualitative interviews who indicated that there needed to be greater consultation with 'grassroots' stakeholders in the development of mental health policy including service users, and local government at the district level:

> *'I would like to see really a debate of issues in the open by all stakeholders before any such policy is developed. We need to talk to all stakeholders, users, we need to talk to workers, we need to talk about the relatives of users, and we need to talk to everybody in the society.'*
> *(Respondent 54, senior academic)*

'….the District Assembly level, that is the grassroots. That is where you can touch the grassroots people. For me I would suggest that the people should be involved in policy making in the country, and then the District Chief Executive and his people should be given the mandate and should be given the necessary logistics and resources to go in and educate the grassroots people with getting their opinions as well and making sure that these opinions from the grassroots people are sent across to the national or for debate and implementation.'
(Respondent 52, trainee counselor, regional level)

There is also a need for research on best practices in mental health on which to base policy directives.

It was noted in the checklist exercise and by respondents that many of the objectives of the policy had not been fully implemented, for example de-centralisation of mental health care, integration with regional and district health services, the establishment of a co-coordinating committee for mental health, and the training of workers for mental health delivery. As this former mental health policy maker noted, the psychiatric hospitals remain the main national resource for mental health care, despite their evident short-comings:

'We thought the Accra psychiatric hospital will not exist after the year 2000, but it is still there, even though it is performing a purpose…. like what it serves is not really giving mental health the desired recognition because the conditions are very poor, the unhygienic conditions… its too big, there are few people to manage it, and the staff themselves have been institutionalized.'
(Respondent 26, former mental health policy maker)

There is also little commitment in the policy towards improving the working conditions of mental health professionals, including maintaining safety and strategies for retention. This was echoed by this respondent who advocated the need for community-based mental health care to enable the de-centralisation of mental health services:

> *'From the grassroots we will be able to progress gradually and reduce the incidence of these conditions before they reach the regional level. So I feel education is very basic and if you want to tackle those points then the community psychiatric nursing should be effective in the country and the policy which is being drawn should be able to cover them, see to their safety and then give them all the necessary incentives so that they will be able to stay in the community and assist. And if this is done, I feel those who will be going to the psychiatric hospital the number will reduce.'*
> *(Respondent 55, senior psychiatric nurse, regional hospital)*

3.4.4 Mental health law development

Over the last ten years there has been an acknowledged need to develop new mental health legislation in Ghana. The current 1972 legislation is out of date and does not accord with the World Health Organisation standards. An attempt was originally made to revise Ghana's mental health legislation in 1996, however the WHO World Health Report on mental health in 2001 (WHO 2001) gave renewed impetus to the movement for mental health law reform. In 2004 a committee was convened to review the existing mental health legislation in Ghana utilising the WHO Checklist on Mental Health Legislation (WHO 2004). The committee consisted of the Chief Psychiatrist and other consultant psychiatrists, psychologists, nurses, the Director of Traditional and Alternative Medicine from the MOH, the human resource manager from Accra Psychiatric Hospital, and a representative of CHARJ, and was supported by an external team of consultants from the WHO Department of Mental Health in Geneva. The details of this review are set out in the completed WHO Checklist on Mental Health Legislation (see Appendix 2).

The development of the new mental health law was praised by participants for the extensive consultation with all stakeholders, from mental health professionals to care givers, and community members:

> *'….. for the first time, we went with nurses, people are on the ward giving all that the policy makers… and then we the administrators…, so care givers are very much involved. And we also took ideas from even those who are looking after…, some community members are*

also involved, so it a holistic something, holistic approach and
participation is quite encouraging.'
(Respondent 45, psychiatric specialist, regional level)

3.4.5 Summary

As with policy-making in general, the development of mental health policy was seen to exclude consultation with key stakeholders at the community level. Policy-making was seen to take place in the cities, without consultation with those living and working in the rural areas. Those responsible for mental health service implementation often felt that policies were pushed onto them from above. The current mental health policy was formulated with little intersectoral collaboration nor grassroots consultation, and requires updating to bring it into line with the newly drafted mental health law. Whilst mental health policy states a commitment to decentralization, the integration of mental health into community-based primary care services, and the training of mental health professionals, in practice this has not occurred. In part this may be due to insufficient attention in the policy to sources of funding for the planned initiatives. Respondents stressed the need for more consultation in mental health policy formulation, particularly with users of mental health services and their families, and with local government at the district level. However the process of mental health law development has involved greater consultation with relevant stakeholders. The 1972 Mental Health Decree was reviewed in 2004 and the formulation of the new draft mental health legislation has drawn on an extensive consultation process at all levels from WHO to community members.

3.5 Content of Mental Health Policy and Law

3.5.1 Content of the 1994 Mental Health Policy

The 1994 Mental Health Policy contains a vision statement which includes human rights, social inclusion, and some commitment to evidence-based practice.

The policy has the following objectives:

1. Decentralisation of mental health services through the development of regional mental health units and outpatient facilities for mental health at the district level
2. Establishment of a national mental health co-ordinating group
3. Establishment of a technical co-ordinating committee
4. Provision of a specialist unit for the management of substance abuse
5. Training of mental health professionals
6. Provision of incentives for the retention of mental health workers
7. Raise mental health awareness for the family and community
8. Establish mental health personnel in regional and district health management teams
9. Provision of transportation for community mental health workers
10. Provision of quarterly and annual reports on mental health activities at regional and district levels
11. Annual mental health service review and planning meetings
12. Training of specialist community mental health workers
13. Rehabilitation of the mentally ill in the community through the provision of rehabilitation centres such as half-way homes and day centres
14. Provision of free psychiatric services

This is consistent with WHO mental health policy objectives for co-ordination and management of mental health services, promoting de-institutionalisation and community-based mental health services, the training of mental health workers, and the need for promotion, prevention and rehabilitation in mental health.

However the policy does not adequately address the following aspects included in the WHO policy checklist:

1. Evidence-based practice
2. Promotion of human rights

3. Provisions for funding of mental health services
4. Legislation
5. Protecting the safety of mental health workers
6. Training of staff in core mental health competencies
7. User advocacy
8. Strategies for intersectoral collaboration

No budget or timeframe is mentioned in the Policy which was judged by the reviewing committee who completed the WHO policy and planning checklists to use 'non-committal language' and to read more like an 'action plan' than a policy The policy states a commitment to free psychiatric treatment, but does not mention the amount, nor the sources of funding.

3.5.2 The Five Year Mental Health Programme

There is a five year programme of work for mental health (2006-2011) which has been drawn up by the Mental Health Unit of the Ministry of Health and Ghana Health Service.

This has the following objectives:
- Reorganization of mental health services
- Promulgation of Mental Health Law and Legislative Instruments
- Establishment of Mental Health Board
- Decentralization
- Training
- Improve quality of care
- Improve infrastructure
- Provide support services
- Promotion of mental health

Some of the plans for achieving these objectives are:
- Dissemination of mental health policy
- Training of workers for mental health, including mental health professionals such as psychiatrists, psychologists and occupational therapists, non-specialists in primary health care and traditional healers
- Standardising diagnoses through the use of the ICD-10

- Provision of mental health workers in district health facilities
- Establishing psychiatric wings in all regional and district hospitals
- Improving quality of care through continuing education and quality assurance
- Improving aftercare and rehabilitation services, including half-way homes
- Provision of essential drugs
- Rehabilitation of the psychiatric hospitals

As with the policy, the Five Year Mental Health Programme had a high level mandate for its establishment, as the Director of Policy Planning Monitoring and Evaluation division of the Ministry of Health was involved as well as the Director-General of the Ghana Health Service, the Chief Psychiatrist and a representative of the Deputy Director of Nursing Services. However, as with the policy, the development of the mental health programme did not include representatives from the ministries of Social Welfare and Housing, representatives from the Criminal Justice System, users of mental health services and their representatives, nor the private sector. There were representatives from the NGO Basic Needs Ghana, WHO and the Royal Netherlands Embassy.

The plan includes strategies and activities that are consistent with the mental health policy and the draft bill. As with the policy, the plan demonstrates a commitment to the development of community-based services for mental health. It also specifies strategies such as community education for the promotion of mental health. However, the plan makes no reference to research as the evidence base. Whilst the document specifies clear timeframes for action, the plan lacks detail on how the objectives would be implemented, nor the sources of funding. There is very limited resource allocation which makes many of the objectives unfeasible. There is also a need for strategies to promote the supply and distribution of psychotropic medication at all levels of the health service, and to improve the structures of mental health information systems. There are no formal structures for intersectoral collaboration mentioned in the plan.

There is no emergency or disaster preparedness plan for mental health in Ghana.

3.5.3 Appropriateness of current mental health policy

Whilst current mental health policy states a commitment to the decentralisation of mental health services, the development of community mental health, and the training of mental health professionals, the lack of dedicated funding, particularly at the regional and district levels, means that mental health policy remains far removed from the reality of practice. Following the documentary analysis conducted for the WHO Mental Health Policy and Plan checklist the reviewing team concluded that:

> *'Mental health is a priority only on paper. In reality it is very poorly resourced. The policy document is well-formulated. However, it is the Ministry of Health which has to decide on the priorities and for now mental health is not one of the priorities.'*

In fact it was felt by the reviewing committee that mental health policy implementation was simply beyond the means of the available resources as reflected in this comment:

> *'There is a lot of lip service in terms of commitment to implement the mental health strategies and plans. Mental health appears too expensive for the policy makers to implement.'*

This view was closely echoed by interview respondents:

> *'…. even though the Ghana Health Service and Ministry realizes that mental health is an important ingredient in the health care delivery system, they have paid lip service and often resources are not given adequately for running of services both at the institutional level and at the community level.'*
> *(Respondent 26, senior psychiatrist)*

> *'….on the ground, I have worked with the Mental Health Unit and sometimes you see the handicap that they go…. I mean in terms of finances, in terms of the support to run even the mental health institutions and so I can say that it is not easy for them, it is not easy for the Mental Health Unit, but otherwise government states clearly in the Programme of Work, that it is, the Ministry of Health Programme of Work, that mental health is also a component of the*

health programme. Where they are talking about integrating mental health into primary health care, they have even gone ahead to… even some region hospitals have designated wards for mental health. So they are trying, is not like a total neglect, but to me, I think if we pump in more support, financially into the sector it would be better.'

(Respondent 16, World Health Organisation, national level)

Therefore whilst there is recognition that some elements of the plan and policy are being rolled out, the failure to allocate adequate resources prevents their full implementation.

Some mental health professionals also queried the current exemption policy of providing psychiatric treatment free of charge. It was felt this was unsustainable in the long term and encouraged families to abandon their relatives at the psychiatric hospitals. Some participants suggested that charges should be introduced for those who can afford it:

'.......even the advanced countries, people contribute something, patients or their relatives, contribute something because the government alone will not be able to pay, especially in a very poor country because the drugs alone are very expensive, buy the drugs, give it free, buy food, give it free, so we think that they should look at the funding and take a more pragmatic decision......'

(Respondent 45, psychiatric specialist, regional level)

3.5.4 Links with other relevant policy

Respondents referred to several government policies, some recently introduced, which have an important bearing on mental health in Ghana. These included policies on education, employment, local government, disability and poverty. The following are some of the policies which were mentioned by participants as having relevance for mental health.

3.5.4.1 The National Health Insurance Scheme

The government introduced the National Health Insurance Scheme (NHIS) towards the end of 2005 to replace the 'cash and carry' system for health care. Children under 18, adults over 70 and 'indigents' are exempted from contributions. By the end of 2005, 22% of the population had registered with the scheme.

The NHIS does not cover psychiatric treatment as this is provided free of charge in the psychiatric facilities such as the psychiatric hospitals and CPN clinics. Patients are therefore not required to register with the scheme in order to receive free psychiatric treatment. However it can prove difficult for patients to access free treatment for psychiatric disorders outside the psychiatric hospitals and specialist facilities. In addition, the costs of treatment for physical health problems are not met if the patient is referred to the general hospitals, unless they are registered with the NHIS. With the understanding that psychiatric services are free, many patients are not registered and so cannot access non-specialist care for physical illness. This situation provides major difficulties for psychiatric facilities which have to pay for medication not listed as psychotropic. A way out of this is for the psychiatric hospitals to register all psychiatric patients with the scheme as indigents. This qualifies them to receive health insurance for free. The mental health facilities would therefore prefer to have mental health services no longer classified as exempt from charges, but fully covered under the NHIS

3.5.4.2 The National Employment Policy

The newly drafted employment policy talks broadly of equal opportunities for all people, irrespective of gender, religion, ethnic origin or political affiliation. One policy maker pointed out that, whilst it makes no specific mention of mental health, the policy promotes equal opportunities for people with disabilities:

> *'The employment policy that we have, or that we've just developed, actually creates equal opportunity for everybody. It doesn't specifically state anything about mentally unsound people. It creates equal opportunity in terms of gender, and then also in terms, you*

> *know, of people with disability. There is nothing specifically targeting*
> *mental health as far as I know.'*
> *(Respondent 17, policy maker, Ministry of Manpower, Youth and*
> *Employment)*

However in practice respondents indicated that people with mental illness were still generally discriminated against in the workplace:

> *'I know some employers do not trust the ability of discharged mental*
> *patients that they are still good as they were before they went in*
> *there, so sometimes they don't even feel like giving them some kind*
> *of responsibilities for fear that they might get relapse.'*
> *(Respondent 19, Department of Social Welfare)*

Thus, not only is there no special provision to assist people living with mental illness to remain in employment for which they are capable despite their illness, but there is also active discrimination to prevent them returning to work.

3.5.4.3 National Disability Policy Document

The National Disability Policy Document was formulated in 2000. Whilst it includes people with mental illness in its definition of disability, it excludes them from its list of the categories of persons with disabilities covered by the policy. The list does however include those with 'mental impairment'. The policy makes no reference to the specific needs of those with mental health problems.

The main policy objectives are:
- To promote the rights of people with disabilities (PWDs)
- To create an 'enabling environment' for the participation of people with disabilities in the national development process,
- To facilitate the access of PWDs to education, training and employment
- To ensure access of PWDs to effective healthcare and rehabilitation
- To combat stigma and social exclusion for PWDs

A National Council on Disability was established within the Ministry of Manpower, Youth and Employment with a membership drawn from all the major organisations for

PWDs, key ministries, and departments, and organisations from the public and private sectors. Its role is to work with existing government agencies, donors and NGOs to implement the policy. A Disability Act was subsequently passed in 2006 (see p.95)

3.5.4.4 Ghana Poverty Reduction Strategy

It was observed during the completion of the WHO checklists that there is no integration of mental health policy with Ghana's poverty reduction and development policies, and that mental health strategies have not been integrated into Ghana's strategic plans for poverty reduction and development. This was echoed by one respondent who observed that mental health policy focuses on the medical management of mental disorder, and does not demonstrate any links to other relevant policies, in particular those which address the development agenda in Ghana, such as the Poverty Reduction Strategy (GPRS):

> *'I think… the most obvious deficiency is the absence of ……a policy that demonstrates linkages to socio-economic aspects of national development or national agenda…..it is just at the level of medical interventions, what happens and all that. So it needs to be extended to include issues of governance, to include issues of the GPRS, to include issues of education and what types of life skills education that people need to know as part of their personal development and goals….When you look at all the other policies, they do not seem to address mental health issues. Take education policy; take socio-economy, presently our medium term development plan, the GPRS, the Ghana Poverty Reduction Strategy. I think the GPRS I was even more explicit on the vulnerable than the GPRS II, and even though we could take comfort in the fact that they said 'marginalized and vulnerable' this one even seems to be more silent…. So the policy environment in Ghana does not much critically address mental health issues or consciousness.'*
>
> *(Respondent 57, director, mental health NGO)*

The 2006 GPRS progress report states that 'The objectives of health sector policy continue to focus on bridging the equity gaps in access to quality healthcare and nutrition services; ensuring sustainable financial arrangements that protect the poor; and strengthening efficiency in health service delivery.' (Government of Ghana 2007b). Whilst this is equally relevant to mental health policy and service provision, there is no mention of mental health within the report. The GPRS notes the poor doctor to patient ratio, and the differential service provision between the north of Ghana and the south. It also notes the barriers to access to health services, particularly for the 'poor and vulnerable': 'Access to health services is however still limited. This could be attributed to a number of factors including socio-cultural, geographical, financial barriers and service delivery constraints. These barriers have resulted in poor utilization of health facilities in both urban and rural areas, particularly among the poor and vulnerable groups of the population' (ibid:102). This inequity is directly echoed in mental health service provision.

The GPRS also addresses the empowerment of women and issues of employment. It states that 'Employment generation and social protection of the vulnerable and the excluded is central to the GPRS II.' (ibid.73). However there are no specific strategies to enhance employment opportunities for the mentally ill. As suggested by the respondent above, arguably those with serious and chronic mental health problems can be included among those who are considered 'vulnerable and excluded.' There is therefore a need for recognition that those who live with serious mental illness need to be specially targeted for help under the GPRS since they are included within this definition.

3.5.5 Content of Mental Health Legislation

3.5.5.1 The Mental Health Decree (1972)

At the time of this report, the existing legislation for mental health was the Mental Health Decree of 1972. This replaced the Asylum Ordinance of 1888 which was enacted by the colonial government. The 1972 decree has the following provisions:

1. Procedures for involuntary admission, including rights to appeal
2. Accreditation of professionals and facilities
3. Enforcement of judicial issues for people with mental illness
4. Mechanisms to implement the provisions of mental health legislation

It was recognised by participants that current legislation is inadequate as it does not promote community mental health care, nor the protection of the human rights of those with mental disorder.

The committee convened to review the 1972 legislation utilising the WHO Checklist on Mental Health Legislation identified several areas which were not adequately addressed in the Mental Health Decree:

1. Provisions for non-discrimination against people with mental disorders
2. The promotion and protection of the rights of people with mental disorders, including the right to humane treatment
3. Provision for financing of mental health care
4. Equitable provision of mental health care
5. The promotion of mental health within primary care
6. The promotion of access to psychotropic drugs
7. The promotion of community-based care
8. Protecting patients' privacy and rights to confidentiality
9. Provision for educational activities, vocational training, leisure activities and religious and cultural needs for people with mental disorders
10. The involvement of users of mental health services, families and carers in mental health policy and legislation development and planning
11. The rights of the family and carers of people with mental disorders
12. Competency, capacity, and guardianship issues for people with mental illness
13. Informed consent to treatment for people with mental disorders
14. The protection of the rights of those patients under involuntary admission, including inadequate definitions regarding the severity of mental disorders requiring involuntary admission, timeframes for the duration of involuntary admission, systematic review and the right to appeal
15. The involuntary treatment of people with mental disorders, including proxy consent
16. Issues of seclusion and restraint
17. The protection of vulnerable groups, including minors and women

The details of this review are set out in the completed WHO Checklist on Mental Health Legislation (see Appendix 5).

3.5.5.2 The draft Mental Health bill 2006

The new Mental Health bill was drafted in 2006 with support from WHO. 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 based approach to mental disorder 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

In its preamble the bill acknowledges that "Progressive legislation which acknowledges the modern trend on human rights can be an effective tool to promote access to mental health care as well as to promote and protect the rights of people with mental disorder."

The bill has nine groups of clauses which cover the following:

- The establishment of a Mental Health Authority to provide mental health care at the Primary Care level
- The provision of mental health services at the regional, district and community level for the treatment, prevention, rehabilitation and counselling of persons with mental disorder, including the services of community psychiatric nurses (CPNs).
- Voluntary treatment, including the reporting of long stay voluntary patients to the Mental Health Review Tribunal
- Involuntary admission and treatment including maximum periods for involuntary admission
- Strengthening of the role of the Mental Health Review Tribunal.
- The protection of the rights of persons with a mental disorder, including equality and non-discrimination, the right to privacy and individual autonomy, and freedom from inhuman and degrading treatment. Other considerations included are the principle of the least restrictive environment and the right to information and participation.
- The protection of vulnerable groups, including women, children and the aged, guardianship, the rehabilitation of persons with mental disorder, the role of the police, and the treatment of offenders with mental disorder
- The establishment of regional visiting committees to inspect mental health facilities and investigate complaints

- Miscellaneous provisions including accounts and audit and the reporting of sudden death, and definitions of terms used in the bill

The Bill has been highly endorsed by WHO as reflecting best practice in mental health legislation (WHO 2007), and its enactment and implementation is seen by actors in the field as vital for the improvement of mental health services in Ghana. Crucial to the success of the law as a framework for the practice of mental health care provision is the collection of accurate and regular data which will inform relevant institutions about the use of services and the protection of the rights of users. This therefore makes a case for the strengthening of the mental health information system.

Several respondents expressed a strong desire for the draft mental health Bill to be passed into law so as to improve mental health care. There was optimism that the new legislation would promote de-centralisation and community mental health care, regulate traditional and faith-based healing practices, and promote and protect the rights of the mentally ill. However some respondents were sceptical as to whether there was sufficient political will and financial commitment to implement the bill once it becomes law. There is therefore a need to develop policies and plans, including the provision of funding, which will ensure that the Mental Health Act is effectively implemented.

3.5.5.3 Links with other relevant legislation

There are several existing laws which protect the rights of citizens of Ghana. Two important relevant pieces of legislation, the Disability Act (Government of Ghana 2006a) and the Domestic Violence Act (Government of Ghana 2007a) have been passed within the last year. Although it was not mentioned by respondents, recent legislation on social exclusion also has direct relevance to mental health.

Constitution of the Republic of Ghana (1992)

Several respondents referred to the Constitution of Ghana as defining the rights of all Ghanaian citizens, including those with mental illness. Clause 12(2) states that 'Every person in Ghana, whatever his race, place of origin, political opinion, colour,

religion, creed or gender shall be entitled to the fundamental human rights and freedoms of the individual.' (Government of Ghana 1992). The new mental health bill highlights the existing rights of people with mental disorder under the provisions of the Ghana Constitution. The bill states that:

> *'A person with mental disorder is entitled to the fundamental human rights and freedoms as provided for in the Constitution'*
> (Government of Ghana 2006b)

Clause 29 of the constitution also has specific provisions for the protection of the rights of those with disabilities, although it makes no specific reference to disability arising from mental disorder. These include the rights of those with disabilities to live with their families and to participate in social, creative or recreational activities, standards for establishments for the care of the disabled, protection against 'exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature' (Clause 29(4)), and the requirement for judicial proceedings to consider the 'physical and mental condition' of the disabled person.

The constitution promotes employment opportunities for those with disabilities. Clause 29 (7) states that 'Special incentives shall be given to disabled persons engaged in business and also to business organizations that employ disabled persons in significant numbers.' It commits parliament to legislation to ensure the enforcement of such provisions (Clause 29(5)).

The constitution also has several provisions relevant in the context of reported human rights abuses in the traditional and faith healing facilities. The constitution enshrines the dignity of the person and outlaws torture or other cruel, inhuman or degrading treatment, as well as 'any other condition that detracts or is likely to detract from [the individual's] dignity and worth as a human being.' The constitution also prohibits inhumane and harmful customary practices. Clause 26(2) states that:

> *'All customary practices which dehumanise or are injurious to the physical and mental well-being of a person are prohibited'*

However some respondents pointed out that the constitution was itself discriminatory as it stipulates that only people of 'sound mind' are permitted to vote:

'If you are mentally unsound, you may not enjoy your full right like somebody who is okay, mentally okay, and this has also been up held by the constitution. When you go to our constitution, I think article fourteen, it says that people of unsound mind, their rights maybe….. curtailed, their liberties…. maybe curtailed…. because of that condition for your own welfare or welfare of the society. So you will not have your freedom like other people.'
(Respondent 84.5, teacher, focus group discussion, district level)

Disability Act (2006)

The Disability Act was passed in 2006 and draws on a rights-based framework for people with disability to ensure equal access to employment and other opportunities, and prevent discrimination on the grounds of disability. Although people with mental illness are included within the definition of those living with a disability, mental illness is not readily recognised by many policy makers and implementers as a cause of disability. Ensuring that people with mental illness are recognised as disabled would enhance their ability to claim rights and benefits under this Act, such as disability payments, thus recognising the additional costs arising from the disabling effects of mental illness, such as loss of employment and loss of income of carers. One respondent explicitly highlighted the rights of the mentally ill under the Disability Act:

'Well presently, you have heard of the disability law. The disabled are saying that they are capable, they can also be DCEs, [District Chief Executives]*, they can be doctors, ministers, provided they are given the opportunity and the push forward. I agree with you that it isn't all of them that will be able to attain the highest level, but the minimum standard that can make them feel accepted by the community, the minimum help that can help them also to live on their own and not always to be dependant to be begging and going round or stealing, those rights must be enforced.'*
(Respondent 60, manager, GES, district level)

However, despite the potential benefits for those with mental illness from the passing of the Disability Act, it is acknowledged that so far the implementation of the Act has been limited.

Domestic Violence Act (2007)

The Domestic Violence Act which was passed in 2007, provides a much needed legal resource for victims of domestic violence in Ghana. Domestic violence including sexual abuse has been linked to depression, anxiety, PTSD, behavioural problems including self-harm, drug abuse and other mental health problems, particularly among women and girls (Fishbach & Herbert 1997).

One respondent explicitly linked domestic violence with mental health problems among women in Ghana:

> *'….. these men, the way they are beating us and harassing us, the woman is there, who is she going to share it? And these women go through this barbaric ways, they cannot say it, because if they are going to say it, they are going to say to their fellow man, and that man is doing the same thing. If there is a problem and we are going to settle, is the men who are going to settle it, and they always say women are wrong. So they keep it to themselves. Before you realize they have developed hypertension, they get stroke. So if someone can get hypertension, some of them deliver, and because of the problem they have… they get postpartum blues. So there is a lot of stress, some of the men, even the moment the woman gets pregnant, that is all no support and they are fending for themselves, always worried, the pressure of life, the marriages, the children, the men don't care, they leave everything for the women to do.'*
> *(Respondent 62, senior public health nurse, district level)*

Perpetrators of domestic violence can now be prosecuted and the passing of the legislation has led to a more open debate regarding the extent of domestic violence in Ghana. However a respondent pointed out that despite advising women to report to the Women and Juvenile Unit (WAJU) of the Ghana Police Service, some were reluctant to do so because they were afraid the husband would divorce them. WAJU has now been replaced with the Domestic Violence and Victim Support Unit which provides counselling for victims of domestic violence. They refer those whom they believe may have a mental illness to the psychiatric hospitals.

3.5.5.4 Areas of action for legislation development

Several steps are necessary in order to develop legislation to promote and protect the needs and rights of those with mental illness living in Ghana. The first task is to provide a clear definition of who constitutes a person living with mental illness and how that person is covered under the Constitution and the various Acts listed above. This clarification, particularly for policy makers and the legislature, would enable the needs of people living with mental illness to be considered under Acts of disability, domestic violence, the constitution, etc.

The second task is a legal one, requiring careful links to be drawn between the existing laws as they apply to this unique group of people living with mental illness.

A third task is the reworking of these important pieces of legislation so that they spell out how they are to be funded. This would compel successive governments to allocate sufficient resources to the vulnerable, including people living with mental disorder, who are covered by the legislation.

3.5 6. Summary

The Mental Health Bill has yet to be sent to Parliament. When enacted into law its advocates think it would transform the practice of mental health care in Ghana. In the last decade there have been some important and encouraging steps taken in Ghana to protect the rights of vulnerable groups. A domestic violence bill and a disability bill have been passed into laws. In addition, the constitution guarantees the rights of people to be free from inhumane treatment. The National Health Insurance Act has the potential to provide free health care if patients are registered. However, more needs to be done in the field of employment policy to provide decent and protected working environments for people living with mental illness. There is also very little explicit reference to mental health in all the related Acts mentioned above. Mental health is not explicitly addressed in policy on poverty alleviation, although strategies to address poverty, such as the GPRS, aim to reach the most vulnerable members of society. It is therefore vital that there is a commitment to enact the Mental Health Bill into an Act, and to give legal backing to the funding of mental health services.

3.6 Mental Health Policy Implementation at the National (Macro) and Regional (Meso) Level

3.6.1 National and regional structures

3.6.1.1 The Ministry of Health and Ghana Health Service

The Ministry of Health has the following directorates:

1. Finance

2. Administration

3. Policy Planning Monitoring and Evaluation (PPME)

4. Research, Statistics and Information Management System

5. Human Resource Development

6. Procurement and Supply

7. Traditional and Alternate Medicine

Ghana Health Service as an agency of the Ministry of Health works through nine divisions. These are:

1. Finance

2. Health Administration and Support Services

3. Human Resources

4. Institutional Care

5. Internal Audit

6. Office of the Director General

7. Policy Planning Monitoring and Evaluation (PPME)

8. Public Health

9. Supply, Stores and Management

The Ministry of Health is responsible for the formulation of policy, and GHS for implementing policy at the regional and district levels. This clear division of responsibilities was described by this respondent:

'If you look at our set up, we have the Ministry of Health which is the policy formulators, they formulate the policies, and then the Ghana Health Service, we are implementers, and of course if you take these two people then the civil society is also a stakeholder..'

(Respondent 45, psychiatric specialist)

3.6.1.2 The Mental Health Unit

Operationally the Mental Health Unit comes under the Institutional Care Division. The Unit oversees the three psychiatric hospitals, the psychiatric wings of the regional hospitals, community psychiatric services and private psychiatric facilities, as well as regulating the practices of traditional and faith healers.

The Mental Health Unit acts as the national mental health authority and advises the government on mental health policies and legislation. The unit is also involved in monitoring and quality assessment of mental health services.

There is a list of essential medicines which includes the following psychotropic medication:

1. Antipsychotics – Chlorpromazine, Haloperidol, Risperidone
2. Anxiolytics – Diazepam, Lorazepam.
3. Antidepressants – Amitriptyline, Fluoxetine, Imipramine
4. Mood stabilisers – Carbamazepine, Sodium Valproate
5. Antiepileptic drugs – Phenytoin, Phenobarbital, Carbamazepine

(Ghana Health Service 2004a)

Although it was not included in the essential medicines list, Olanzapine has also been available since 2004.

3.6.2 Financing of Mental Health Services

It was not easy to obtain precise figures for mental health expenditure in Ghana. 6.2 % of the health care budget of the Ministry of Health is dedicated to mental health. It also became clear through interviews with mental health professionals and Ministry

of Finance officials that some moneys are routinely sent to the micro level directly from the Ministry of Finance as part of the de-centralisation process, without the knowledge of some macro (national) and meso (regional) level authorities. This made it difficult to accurately compute the exact budget allocated to mental health in Ghana.

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 participants as 'woefully inadequate'. Participants reported that funds are quickly absorbed in meeting the basic needs of the patients, and recalled that the psychiatric hospitals had recently run out of sufficient funds to feed the patients.

Furthermore participants reported there are few resources remaining to fund psychosocial and rehabilitative interventions in the hospitals such as occupational therapy.

GRAPH 1: HEALTH EXPENDITURE TOWARDS MENTAL HEALTH
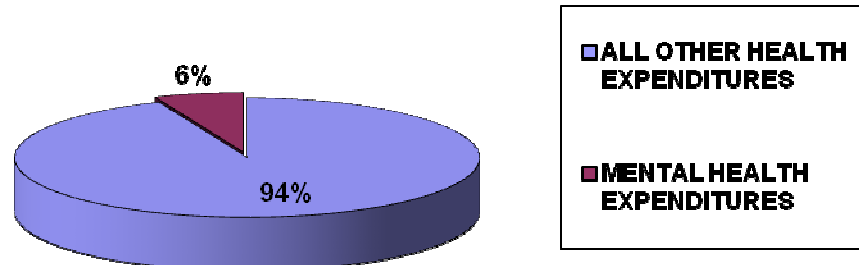
GRAPH 2: MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS
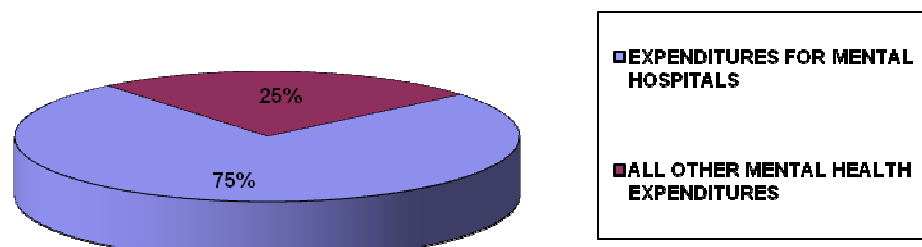
At the regional and district levels there is no allocated budget for mental health. Since the psychiatric hospitals are funded directly from the Mental Health Unit at the national level, the psychiatric hospitals are virtually autonomous from regional health administration. This means the psychiatric hospitals are not integrated into regional health structures. With the advent of psychiatric wings in the regional hospitals, there is a need for closer collaboration between regional and district levels in the administration of mental health care. As revealed by this respondent at one of the psychiatric hospitals, some level of integration between psychiatric and primary health care services is occurring, however this needs to be strengthened:

> *'....our allocation comes direct from the Ministry of Health so it's like the regional level, they don't have control over us, so they stay away from us. But this time we should work together. We should participate in their activities that are important. Now that they are forming mental health units in all the regional hospitals, there are CPNs at the regional level. So this management aspect of it has been reviewed. We are collaborating with the regional and the district directors and then participating in their activities.'*
> *(Respondent 12, psychiatric hospital)*

As mentioned above, psychiatric treatment, including psychotropic medication, is free in Ghana. However several respondents indicated that the supply of psychotropic drugs to inpatient and community facilities is often insufficient, leading to shortages of essential medication:

> *'We get some shortages. We have only 22 drugs, 22 approved essential drugs. In most cases, we don't have even at least three-quarters of the drugs available in most cases. Last year for example, the government had to purchase about 12 billion* [old Ghana Cedis] *worth of drugs for us, they were able to purchase only 4.3 billion, the rest never came. So we kept on writing "nil" or substituting, making substitution of drugs. That is the problem, that we have… we never get self-sufficient in drugs supply.'*
> *(Respondent 7, pharmacist, psychiatric hospital)*

When medication is unavailable at the hospital pharmacies and clinics, patients must purchase the necessary medication at their own expense:

'….the drug flow is low; with the rate at which we get the drugs is still the problem. Sometimes, it comes and the people keep on increasing, I think they have limited their rate of supply, so now the people are more than the drug that is usually requested for time code, so that is where we have the problem. And the drugs outside is quite expensive, so when it is like that the patients find it difficult to go outside to buy, some don't even have the money to go and buy'
(Respondent 44, psychiatric nurse, regional level)

'…..even drugs for our clients you don't get…So what happens? There is stigma attached to the condition already, and the poor patient suffers because you go to hospital, the drug is not there. So it will be prescribed and if you can't afford to buy it, what do you do? And our drugs too are expensive.'
(Respondent 40, CPN)

Therefore although psychotropic medication should be free in principle, in reality patients often have to buy medication on the open market at prices they often cannot afford.

The cost of the average maintenance dose per day of the cheapest anti-psychotic, 300mg Chlorpromazine is about 0.75 Ghana cedi. This represents 58% of the minimum daily wage of 1.3 Ghana cedi for the index year 2005. The cost of the average maintenance dose per day of the cheapest anti-depressant, 75mg Amitriptyline, is about 0.3 Ghana cedi, which represents about 23% of the daily minimum wage.

3.6.3 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 community-based 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.

The psychiatric hospitals maintain data on the number of involuntary admissions. However there are no records on patients who are restrained or secluded.

There was no training in the protection of the human rights of patients in the inpatient psychiatric units and community residential facilities in the year under review.

3.6.4 Mental health services

In the following section information is drawn from WHO-AIMS with some additional data from the qualitative interviews and focus groups. For definitions of terms used, please see the glossary of terms from the WHO-AIMS in Appendix 1. Some of the data was not available, in which case, best estimates were made where feasible. The completion of the WHO-AIMS revealed some of the weaknesses of the health information system employed within health services in Ghana which are highlighted through some of the inconsistencies and omissions in the data.

3.6.4.1 Psychiatric outpatient facilities

There are 68 outpatient mental health facilities available in the country. This includes 56 clinics run by the CPNs, the outpatient departments of the 5 regional hospitals which have psychiatric units, and the outpatient departments of the 3 psychiatric hospitals. In addition there are 4 outpatient departments in the private psychiatric hospitals.

Outpatient attendance

Data for attendance at outpatient facilities was only collected from the three state psychiatric hospitals and therefore represents a considerably lower figure than total

outpatient attendance at psychiatric facilities. There are some difficulties in collating statistics for outpatient attendance at the psychiatric hospitals due to differences in recording.

Table 1: Outpatient attendance at psychiatric hospitals 2005

	Male	Female	Total
Accra – Old	18,323	21,667	40,057
Accra – New	2,139	2,015	4,154
Pantang	6,922	5,963	12,885
Ankaful	N/A	N/A	28,907
TOTAL	N/A	N/A	86,003

The number of new cases who attended the outpatient department (OPD) at the Accra psychiatric hospital in 2005 was 4,154, of which 2,139 were male and 2,015 were female. However in addition 40,057 old cases attended Accra psychiatric OPD, of which 18,323 were male and 21,677 were female. 12,885 psychological cases attended Pantang hospital as outpatients in 2005 for psychiatric treatment, of which 5,963 (44%) were female. At Ankaful Psychiatric Hospital 28,907 psychological cases attended in 2005. There are no statistics on gender.

There is some overlap in these statistics since some patients attend more than one psychiatric hospital. Also despite distinguishing between old and new cases, it is possible that patients who make multiple attendances may be recorded more than once. The average number of contacts per user is not recorded.

Diagnosis

Data on diagnoses at outpatient departments was only available from two of the three government psychiatric hospitals. Diagnoses are not recorded under ICD-10 categories, and diagnostic categories vary between the three hospitals. Therefore there is some potential for discrepancy and overlap. For example, 'cannabis psychosis' could also be recorded under 'psychotic disorders'. Among the 'other disorders' recorded at the hospitals, epilepsy represents by far the greatest single proportion and has therefore been separated from 'others'. Other disorders recorded in the 'others' category included febrile convulsion and tension headache.

Table 2: Outpatient diagnoses at psychiatric hospitals 2005

Diagnosis	Accra	Pantang	Ankaful	Total	%
Mental and behavioural disorders due to psychoactive substance use (F10-F19)		1110 (substance/ alcohol abuse)	331 (cannabis psychosis)		
Schizophrenia, schizotypal, and delusional disorders (F20-F29)		6646	457		
Mood, affective disorders (F30-F39)		1591	798		
Neurotic, stress-related and somatoform disorders (F40-F48)		270 (anxiety disorder)	138 (somatization disorders)		
Disorders of adult personality and behaviour (F60-F69)		0	0		
Epilepsy /seizure disorders		2454	1412		
Others*		189	535*		

*includes febrile convulsion, tension headache

Children and adolescents

At Accra psychiatric hospital 804 new cases were under 19 years. 461 of these were male, and 343 were female. The number of children and adolescents under 17 years seen at Pantang in 2005 was 622. At Ankaful 1152 patients 19 years and younger were seen in outpatients. 599 were male, 553 were female. There are no dedicated outpatient facilities for child and adolescent mental health.

Table 3: Numbers of children and adolescents attending OPD at psychiatric hospitals 2005

	Male	Female	Total
Accra – New (under 19)	461	343	804
Pantang (under 17)	N/A	N/A	622
Ankaful (under 19)	599	553	1152
TOTAL	N/A	N/A	2578

Table 3 reveals some of the weaknesses of the information systems within psychiatric services as stated at the introduction to this section. The three psychiatric hospitals have no uniform age to distinguish between children and adults, just as they do not employ standardised illness categories in their records.

No records are collated on referrals from outpatients departments to community services. It is estimated that about 80% of outpatient facilities provide follow-up care in the community through referral to CPNs. No outpatient facility has a mental health mobile team.

3.6.4.2 Psychiatric day treatment facilities

There are two 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 the NGO Basic Needs, and Shekina, run by a private practitioner. There are no day treatment facilities within GHS.

3.6.4.3 Community-based psychiatric inpatient units (Psychiatric inpatient units in regional hospitals)

There are 5 community-based psychiatric in-patient units available in the country providing a total of 77 beds, that is 0.33 beds per 100,000. These are provided within 5 of the 10 regional hospitals.

The breakdown of beds available in the psychiatric wings in the regional capitals is as follows:

Table 4: Number of psychiatric beds in regional hospitals

Town	Region	Number of beds
Ho	Volta	10
Kumasi	Ashanti	15
Wa	Upper West	10
Koforidua	Eastern	20
Sunyani	Brong-Ahafo	22
TOTAL		77

None of the beds in community-based inpatient units are reserved for children and adolescents only.

No data was collected from the regional psychiatric units. The diagnoses of admissions to community-based psychiatric inpatient facilities, the average number of days that patients spend on admission, the number of involuntary admissions, and the proportion of children and females admitted is therefore unknown.

3.6.4.4 Community residential facilities

Cheshire Home in Kumasi provides rehabilitation for people with mental disorders. There are no other known community residential facilities as defined by WHO-AIMS (but see Section 3.6.4.6).

3.6.4.5 Mental hospitals

There are three government-owned psychiatric hospitals available in the country, providing 7.04 beds per 100,000 of the population. Accra Psychiatric Hospital located in Accra has 800 beds, Pantang Hospital just outside the capital has 500 beds, and Ankaful Psychiatric Hospital close to Cape Coast in the Central region has 250 beds. The hospitals are organizationally integrated with mental health outpatient facilities. The psychiatric hospitals are overcrowded and there are insufficient beds for the numbers of patients, with many sleeping on mats on the floor. Accra Psychiatric Hospital, for example, has 800 beds, but accommodates approximately 1,100 patients at any point in time.

There are 45 dedicated beds for children and adolescents in the psychiatric hospitals, representing 4% of the total number of hospital beds.

In addition to the government hospitals, there are 4 private psychiatric institutions which provide outpatient clinics and inpatient care. Valley View hospital in Accra has approximately 30 beds. Pankronu and Adom clinics in Kumasi, the second city in Ghana, have 16-20 beds each. Alberto Clinic in Tema, close to Accra Has an unknown number of beds.

Admissions

A total of 6,454 inpatients were admitted to the 3 state psychiatric hospitals in 2005. Approximately 50% of these were female.

Table 5: Inpatient admissions to psychiatric hospitals 2005

Hospital	Total
Accra	3,597
Pantang	1,114
Ankaful	1,743
TOTAL	6,454

Diagnosis

Diagnoses were collected only for admissions to the three government psychiatric hospitals. Again these represent some difficulties as there are variations in recording between the three hospitals and diagnoses are not recorded according to ICD-10 categories.

Table 6: Inpatient diagnoses at psychiatric hospitals 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

The most frequently recorded diagnoses at the state psychiatric hospitals are psychotic disorders (37.4%), followed by substance abuse disorders (22.8%) and mood disorders (19.0%). Among the substance abuse disorders the majority were recorded as due to cannabis use. The rest were alcohol-induced disorders. There are no recorded diagnoses of personality disorders nor neurotic, somatoform or stress-related disorders among inpatients. At Accra psychiatric hospital 639 cases (18% of inpatients) were recorded as 'other'. This contrasts with 25 cases at Pantang hospital (2.2% of inpatients). The reasons for this remain unexplored but may be due to the limited amount of time available for consultation, incomplete record-keeping, deficiencies in clinical expertise with regards to the less common forms of mental illness, or for a few cases the limitations of diagnostic categories to reflect the presentation of some Ghanaian patients.

GRAPH 3: INPATIENTS TREATED IN MENTAL HOSPITALS BY DIAGNOSIS 2005

	MENTAL HOSPITALS
■ MOOD DISORDERS	19%
□ OTHERS	21%
□ PERSONALITY DIS.	0%
□ NEUROTIC DIS.	0%
■ SCHIZOPHRENIA	37%
□ SUBSTANCE ABUSE	23%
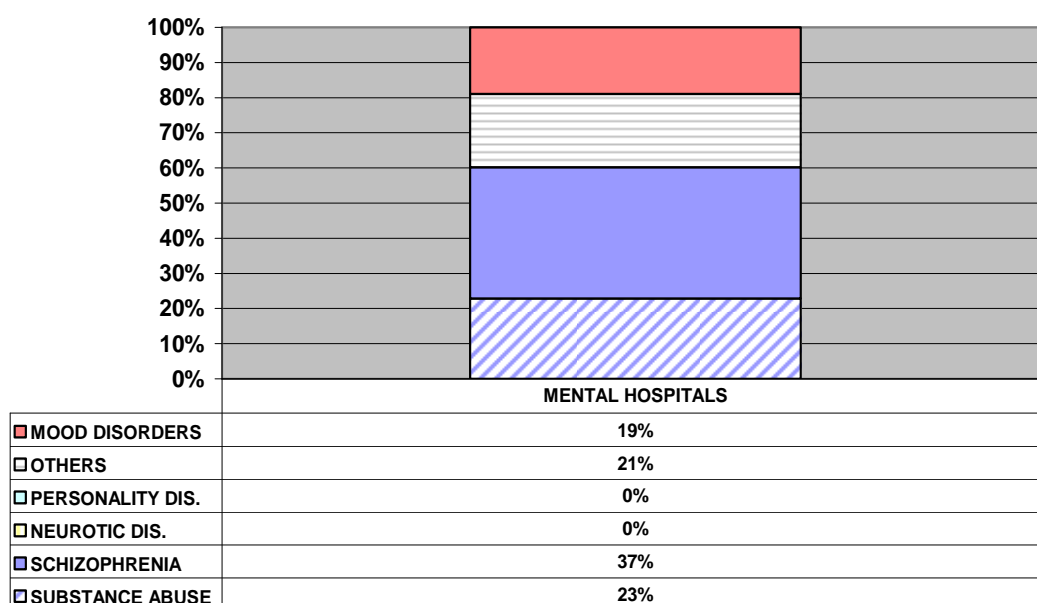
There were 65 involuntary admissions to Pantang in 2005. There are no available figures for the other psychiatric hospitals.

There were 205 long-stay patients at Pantang in 2005. There are no figures for the other psychiatric hospitals. The average length of stay at Ankaful psychiatric hospital in 2005 varied depending on the ward ranging from 46.3 days to 364.1 days. The total average was 82.2 days. The average length of stay in Pantang hospital in 2005 was 285 days. There are no figures from Accra psychiatric hospital on length of stay. However it is known that all the state psychiatric hospitals have long-stay patients who are considered to be recovered, but who continue to remain in hospital. In Accra Psychiatric Hospital in 2007, 520 patients were said to be ready for discharge. One of the reasons for this is due to the stigma attached to mental disorders, which can result in relatives or caregivers abandoning the person at the psychiatric hospitals. In addition, so long as 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, as argued by this respondent:

> *'So in psychiatry now it is patients just coming in, and then going out, and then coming back again. It's an expected thing that happens. 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.'*
> (Respondent 7, pharmacist, psychiatric hospital)

In addition without the provision of secure hospitals, some offenders who have been ordered by the courts to attend for psychiatric assessment can remain in the psychiatric hospitals for many years.

3.6.4.6 Forensic and other residential facilities

In Accra psychiatric hospital there is a dedicated forensic ward with 15 beds. However this is not used solely by forensic patients. In Pantang hospital in 2005 there were 88 forensic patients. There are no figures for forensic patients in Accra and Ankaful hospitals.

There are 15 beds in an inpatient rehabilitation facility near Elmina which forms part of Ankaful Psychiatric hospital. There are 6 known community residential facilities run by voluntary and church organisations which provide drug rehabilitation. These are Remar, a faith-based organisation with facilities in Accra, Aflao, Nsawam, Kumasi and Tema, and the Mercy Centre at Brafo-Yaw near Cape Coast.

There are 10 residential facilities for children under 17 with mental retardation, one in each of the regions. In addition, Operation Hand-in-Hand, an NGO provides residential care and rehabilitation in Nkoranza in the Brong Ahafo region for mentally retarded children There is also a private school, New Horizon, for children with learning disabilities in Accra. There are 2 private residential facilities for people with substance abuse. Valley View hospital in Accra has one detoxification unit.

There are no residential facilities for people with dementia. However there are dedicated beds for male and female geriatric patients at the Accra Psychiatric Hospital.

3.6.4.7 Availability of psychosocial treatment

It is estimated that between 1-20% of patients received some form of psychosocial intervention within mental hospitals, community-based psychiatric inpatient units, and outpatient mental health facilities in 2005. This is largely in the form of occupational therapy, psychotherapy, counselling and social work.

3.6.4.8 Availability of psychotropic medication

All mental hospitals, community-based psychiatric inpatient units, and outpatient mental health facilities units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility in the index year.

However the range of psychotropic drugs available within GHS is limited. The new generation of anti-psychotics or 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, and there is limited availability of depot anti-psychotic medication within GHS, especially outside the psychiatric hospitals. Whilst most drugs can be obtained privately, they are beyond the means of the great majority of those requiring treatment. The side effects of the older anti-psychotics can also be an impediment to adherence on the part of patients.

3.6.4.8 Human rights and equity

The numbers of patients who were admitted involuntarily to Pantang Hospital in 2005 is 65. The numbers of patients who were physically restrained and/or secluded in the government psychiatric hospitals in 2005 is unknown as no records are kept.

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. Such a distribution of beds impedes access for rural users.

There are no specific strategies in place in health facilities to ensure that linguistic minorities in Ghana can access mental health care in a language in which they are fluent. For example there are no official interpreting services. Family members or staff who speak the patients' language will normally act as interpreters. Patients who have received little education and do not speak English may be at some disadvantage since ward rounds and the provision of information, such as notices and signage in the psychiatric facilities, are all in English. The development of community radio stations which broadcast in local languages has provided a forum for the provision of health information in the vernacular and have been used, for example, in advertising the new health insurance scheme. TV stations also broadcast in Akan languages, however many poorer households do not have access to television nor electricity.

3.6.5 Mental health in primary health care

Doctors working in the district hospitals 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 staff with lower levels of training such as community health nurses 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 for health conditions. These are available in the standard treatment guidelines provided by the GHS, which include guidance on the treatment of the major psychiatric conditions including schizophrenia and depression (GHS 2004).

The following information is approximate as detailed data on mental health is not routinely collected in many primary health care facilities. However in 2005 data on psychiatric morbidity as recorded within outpatient consultations at district health facilities was collated at the regional level, This is based on four psychiatric categories: epilepsy, acute psychosis, neurosis and substance abuse (see Table 7).

However this is likely to be a significant underestimate of 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. Since 2007 this data has been disaggregated according to age-range and gender. However the same limited number of disease categories are retained and are problematic for recording cases since they do not reflect internationally standardised diagnoses and omit a category for non-acute psychotic disorders and affective disorders.

Table 7: Outpatient psychiatric morbidity 2005 per region

Disease	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, E= Eastern, ASH=Ashanti, BAR= Brong Ahafo, NR= Northern, UER= Upper East, UWR= Upper West

It is estimated that between 80-100% of primary health care doctors make on average at least one referral per month to a mental health professional. Between 21-50% of primary health care clinics are estimated to refer patients presenting with mental health 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.

In terms of professional interaction between primary health care staff and other care providers, it is estimated that between 1-20% of primary care doctors have interacted with a mental health professional at least once in the last year. This is mainly in the form of outreach services conducted by mental health professionals. However it was reported that communication and collaboration between health care workers and psychiatric services is poor and that the physical health needs of the mentally ill are often neglected:

> *'…these days the mortality for mental patients is rising because of the underlying physical factor, and the general hospital, the moment they identify the psychological problems, they say: "Oh take the patient to the mental hospital", meanwhile they have failed to treat the underlying physical condition. When the person comes here, before we realize, because of inadequate staff, there is very low observation, and before we realize, the person is off, and that is a very big problem. And now we are experiencing high trend of mortality in the mental hospitals, so there is a need to collaborate so that others will know how to treat mental patient.'*
> *(Respondent 47, senior staff member, psychiatric hospital)*

Between 1-20% of workers in the district hospitals and primary health care clinics are estimated to have had contact with a traditional or complementary practitioner, however no records of such contacts are maintained.

3.6.5.1 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 was no data available on how many primary health care doctors and non-doctor/non-nurse primary health care workers had received at least two days of refresher training in mental health in the index year. However responses from the qualitative data indicated that in-service training in psychiatry is limited. Many of the primary health care workers contacted stated that they have had no training in psychiatry since they completed their initial clinical training:

> *'…with regards to mental health I can confidently say that, since I completed SRN, the basic courses, I have never…. I mean, a mental health workshop has never been organised for us. So every time you have to read whatever you come across and use that knowledge to share with other people. That is the neglected aspect.'*
> *(Respondent 62, senior nursing officer, district level)*

3.6.5.2 Prescription in primary health care

Primary health care workers in charge of non-doctor/non-nurse facilities are allowed to prescribe psychotropic medications with some restrictions. Beyond this, they are required to refer to a higher level.

It is estimated that 80% of the district hospitals have at least one form of psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic), in comparison to 20% of primary health care clinics.

3.6.6 Human resources in mental health care

3.6.6.1 Number of human resources in mental health care

The breakdown of human resources working in mental health facilities in 2005 per 100,000 population is as follows: 0.068 psychiatrists, 0.045 other medical doctors (not specialized in psychiatry), 2.58 nurses, 0.004 psychologists, 0.027 social

workers, and an unknown number of other health or mental health workers including auxiliary staff, health assistants, paramedics and medical assistants. There are 15 psychiatrists for a population of 22 million.

GRAPH 4: HUMAN RESOURCES IN MENTAL HEALTH 2005
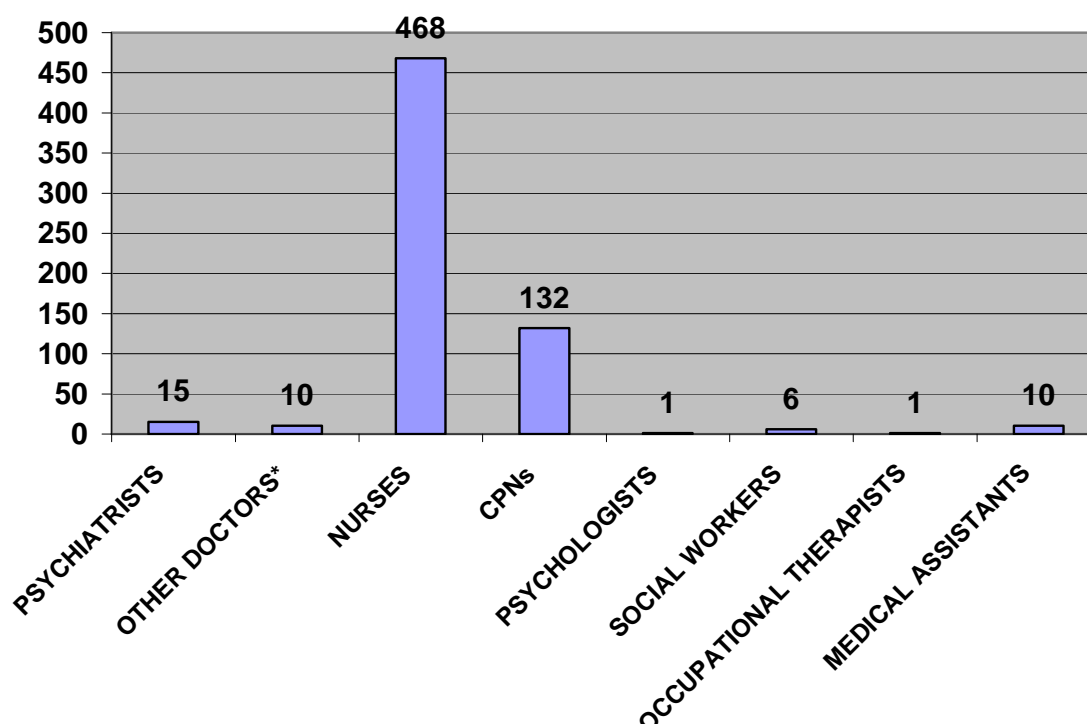
* Doctors have one year's training in psychiatry

NB: Psychiatrist, doctors, psychologists, social workers and medical assistants also work within outpatient clinics within psychiatric hospitals. CPNs work only with outpatients. The number of psychiatrists and doctors includes those working within regional psychiatric units (community-based psychiatric inpatient units)

The distribution of human resources between urban and rural areas is heavily weighted towards urban areas of the south. 10 out of the 15 psychiatrists in Ghana work in or near the capital city. The vast majority of psychiatric nurses are also employed in the psychiatric hospitals of the south. The ratio of nurses to 100,000 of the population is 6.29 times greater in Accra than in the entire country.

Psychiatrists

In 2005 there were 15 practising psychiatrists in Ghana. However 9 of these were retired and working on contract for a limited number of hours, and 2 were working in private practice. Only 4 psychiatrists of working age were employed within GHS in 2005. In addition there were 10 doctors with a diploma from the West African College of Physicians: 2 of these were also retired and 3 were close to retirement.

No psychiatrists work in outpatient facilities alone as all combine inpatient and outpatient work. In 2005 6 psychiatrists were working within the 3 public psychiatric hospitals, and 3 psychiatrists were working in community-based psychiatric inpatient units.

In terms of staffing in mental health facilities, there are 0.04 psychiatrists per bed in community-based psychiatric inpatient units and 0.03 psychiatrists per bed in the psychiatric hospitals. However the proportion of psychiatrists to beds in the mental health in-patient facilities in Ghana, especially the psychiatric hospitals, does not represent the true patient to professional ratio due to overcrowding (see Section 3.6.4.5).

Psychiatric nurses

In 2005 there were approximately 436 psychiatric nurses working in the psychiatric hospitals in Ghana and 132 CPNs based in the ten regions covering 69 of the 138 districts. Some of these CPNs provide outreach services to neighbouring districts. Some CPNs work in clinics and others are attached to district hospitals. However many CPNs are nearing retirement and there is no programme for their replacement. Psychiatric nurses in Ghana have also been subject to high rates of attrition from the GHS with many moving to work abroad. The number of nurses working in private psychiatric facilities is not known.

Psychologists

In 2005 there was only 1 psychologist working within mental health facilities within Ghana Health Service, with a further 6 based within the medical schools at Korle Bu teaching hospital in Accra and Komfo Anokye teaching hospital in Kumasi. One of the reasons for the low numbers of psychologists is that there is no pay structure for psychologists to be employed within Ghana Health Service. There are no community-

based psychologists. The number of psychologists working in private psychiatric facilities is not known.

Social workers

There is no specialist training for psychiatric social workers and no dedicated social worker for mental health working in the community. In 2005 there were 2 social workers working in each of the state psychiatric hospitals.

Occupational therapists

There is only one occupational therapist employed at Pantang hospital who is now retired and working on contact. The occupational therapy units at the psychiatric hospitals are run by occupational therapy assistants and artisans such as seamstresses and carpenters. In 2005 there were 18 occupational therapy assistants working within inpatient facilities. There are no community-based occupational therapists.

Other
9 medical assistants were employed within the psychiatric hospitals in 2005. One other medical assistant works within a CPN clinic.

There are also an unknown number of health assistants, some of which received 6 months training in mental health under an initiative at the Psychiatric Nurse Training Colleges.

3.6.6.2 Training professionals in mental health

The number of health professionals who graduated from academic and educational institutions in 2005 is as follows: approximately 190 medical doctors (not specialized in psychiatry), 0 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). No occupational therapist has been trained within the period under review, as no training facilities for occupational therapists currently exist in Ghana.

GRAPH 6: PROFESSIONALS GRADUATED IN MENTAL HEALTH 2005
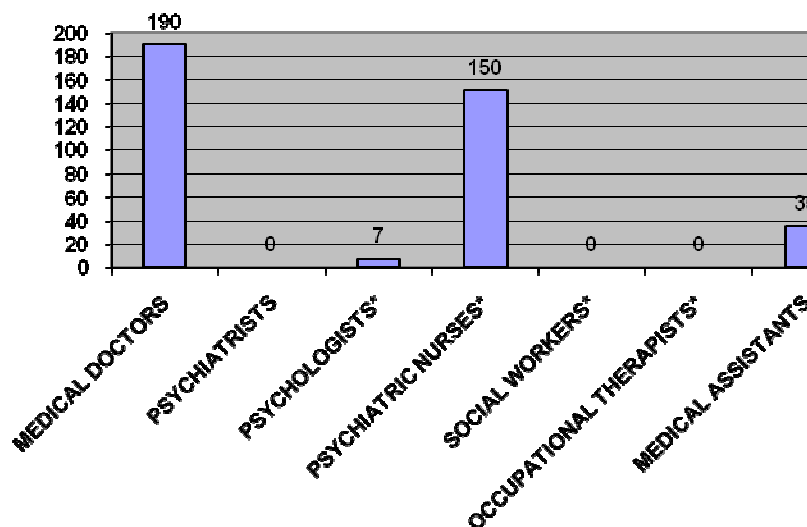
*with at least one year's training in mental health care

The two psychiatric nurse training colleges in Ghana at Ankaful and Pantang hospitals have significantly increased their intake since 2005 in order to address the shortfall in psychiatric nurses. Both Pantang and Ankaful now have 200 places each for psychiatric nurse training. In 2005 the colleges provided 6 months training for nursing aids to be employed in the psychiatric hospitals, however this training is no longer running due to lack of resources.

No psychiatrists emigrated to other countries within five years of the completion of their training within the year under review.

The percentage of staff with at least two days of refresher training in the rational use of psychotropic drugs, psychosocial interventions and the handling of mental health issues of adolescents and children is not known, as this data is not routinely collected. However staff indicated that due to resource constraints, in-service training was rarely available:

> '… some educational beef-up that we have to give to the nurses for them to perform very well, but because we are constrained, we don't have the money for it, that budgetary allocation to push our nurses to go and learn something. Even if there is something new…, even if

there is a new drug out, and then somebody has got the pamphlet or something to show, because of this financial constraint we can't organize the nurses to teach them to upgrade themselves into something.
(Respondent 35.1, psychiatric nurse, focus group discussion)

3.6.6.3 Consumer, family associations and other NGOs

There is a family support group at Accra Psychiatric Hospital. In 2005 there were approximately five mental health NGOs known to be operating in the country, involved in activities such as counselling, vocational rehabilitation, advocacy or support for people with mental illness. Basic Needs, which operates in Accra and in the north of the country, draws on a rights-based framework for mental health and is involved in strengthening the provision of community mental health care, advocacy, family support, and vocational rehabilitation. Basic Needs provides outreach clinics to the Upper West, Upper East and Northern regions, and in Greater Accra, and have trained volunteers to work alongside CPNs in the community to detect and refer cases of mental illness. The Psychomental Association was established by staff from Accra Psychiatric Hospital and mainly works to raise awareness of drug abuse issues.

The Friends of Accra Psychiatric Hospital is a coalition of women's groups mainly from the Presbyterian and Methodist churches who engage in fund-raising and provide some support for mental health, mainly in the form of donations of food and clothing for the psychiatric hospitals. They also sponsor the wards at Accra Psychiatric Hospital and pay for such things as renovation and redecoration.

Mindfreedom, an NGO which was established in 2004, draws on the international mental health user movement to advocate for the rights of those with mental disorders. It works closely with Basic Needs to support users in the community.

3.6.7 Public education and links with other sectors

3.6.7.1 Public education and awareness campaigns on mental health

There is no coordinating body to oversee publications and awareness campaigns regarding mental health.

Some 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. 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. No campaigns have been organised for children, trauma survivors, ethnic groups or other vulnerable minority groups.

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 (Doku et al. 2006). Newspaper articles are only accessible to those who read English.

No private trusts or foundations have been involved in the promotion of mental health and awareness campaigns in Ghana.

3.6.7.2 Links with other sectors

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.

The percentage of prisoners with psychosis and mental retardation in the prisons is not known. The percentage of prisons who have at least one prisoner per month in treatment contact with a mental health professional is not known as no records are kept of mental health cases within the prison service.

As regards training, the number of police officers, judges and lawyers who have participated in educational activities on mental health in the last five years is not known. Considering the responses provided in the qualitative data it is probable that very little or no training programmes were conducted. Police officers at the district level for example, reported receiving no training in mental health.

In terms of financial support for users, none of the mental health facilities have access to governmental programmes outside the mental health facility that provide employment for users with severe mental disorders.

There are no social welfare benefits as such available in Ghana. The District Poverty Alleviation fund is available for those facing severe economic hardship. Since 2006, 5% of the District Assemblies' Common Fund is also dedicated for the 'physically challenged'. Social welfare departments can make discretionary payments to the destitute, for example meeting their emergency medical costs. Some financial assistance is also provided by the psychiatric hospital social work departments to send discharged patients back to their communities.

3.6.8 Summary

Ghana has limited psychiatric provision for the treatment of mental illness with few specialist facilities and psychiatric health professionals. The vast majority of the national budget for mental health is absorbed by the three psychiatric hospitals. There is no dedicated budget for mental health at the regional and district levels.

Specialised psychiatric care remains centralised. Whilst there is some integration of mental health within primary health care, there are very limited community-based

mental health services and many of the districts in the country are without a single mental health professional. Inpatient psychiatric care is largely concentrated in the south of the country and only half of the country's regions have dedicated psychiatric units in the regional hospitals. Access to mental health care is therefore severely restricted for the majority of the population.

Psychotic disorders are the most frequent diagnosis in the psychiatric hospitals, representing almost 40% of inpatient admissions. Substance use disorders are the second most frequent diagnosis. Mood and affective disorders constitute the third most frequent diagnosis. Neurotic disorders are rarely categorized and recorded as such and may form the bulk of the category denoted as 'others' together with personality disorder. There are also many undiagnosed cases. The psychiatric hospitals have many long-stay patients who whilst recovered are unable to be discharged as many have been abandoned by their families. There is a lack of facilities for psychosocial rehabilitation to assist such patients.

Given the very limited number of qualified mental health professionals such as psychologists, psychiatric social workers and occupational therapists, treatment for mental illness within Ghana Health Service is largely restricted to psychotropic medication with very little availability of psychosocial therapies and interventions. Whilst psychotropic medication is provided free of charge at the hospitals and clinics there are problems in both the supply and distribution of psychotropic medication, particularly in remote areas.

Training in mental health is limited at all levels, both for primary care workers and within other sectors, such as the police. Professionals in mental health care reported receiving no refresher training.

3.7 Mental Health Policy Implementation at the District (Micro) Level: Case study of Kintampo North District

3.7.1 Overview of facilities, resources and services

3.7.1.1 Structure of health services in Kintampo North district

Table 8: Health facilities and resources in Kintampo District (2005)

Facilities		Clinical Staff	
No of hospitals	1	Doctors	3
Fixed clinics	6 (2 private)	Psychiatrists	0
Mobile clinics for PHC	0	Psychologists	0
Mobile clinics for MH	0	Medical Assistants	2
Dedicated beds	0	Nurses	45
Community residential	0	Nursing aids	unknown
Child and adolescent dedicated	0	Social Workers (community)	2
Outreach offices	2 (1 CHPS compound)	Occupational Therapists	0

District management

The Kintampo District Health Directorate represents GHS at the district level. The Directorate is responsible for the implementation of health policies and interventional programmes at the community level, as well as providing clinical services through health centres and community clinics. For purposes of health service delivery, the district has been demarcated into 7 sub-districts which each have a health centre, rural clinic or outreach office. These are staffed by Community Health Midwives, Technical Officers and Field Technicians.

The District Health Management Team (DHMT) is responsible for supervising all the health care activities that take place in the health centres and clinics in Kintampo North district as well as overseeing the district hospital at Kintampo. The DHMT is headed by the District Director of Health Services and has 16 staff including a public health nurse, an accountant, a biostatistician, a nutritionist and a disease control officer. The DMHT also includes the Medical Superintendent, the District Director of Nursing Services and the administrator of the district hospital. Data collated by the DHMT is reported to the Regional Health Directorate in the regional capital Sunyani, which provides support during strategic health planning and plays a supervisory role in the activities of the DHMT.

In addition to supervising the clinical activities of the health facilities in the district, the DHMT has an important role in public health and health promotion, including health education and outreach services to the communities in the district. The DHMT is also responsible for regulating the activities of the private clinics and maternity homes in the district.

The DHMT was reported by respondents to face problems of staff shortages, inadequate funding and difficulties in accessing the rural areas, particularly in the rainy season when many roads become impassable:

> *'The other problem is, the rural areas we have difficulty having the people, especially when the rains start, they are cut off. So for health services to reach them is a problem. And this year in particular the release of funds for our programme has been very erratic and woefully inadequate. We also do not have enough staff. If you look at the whole of this district, community health nurses are only four. We only have two medical assistants in the hospital, the rest of the hospital facilities do not have medical assistants.'*
> *(Respondent 62, senior public health nurse, district level)*

Mental health was generally seen as a neglected area in the district. There are currently no staff dedicated to managing mental health in the district. Participants at the district level suggested that mental health should be included in the public health activities of the DHMT, and that there should be a mental health unit under the DHMT, responsible for supervising mental health care and mental health promotion in the district. The DHMT is responsible for collating statistics on health problems in

the district, including mental health. Diagnoses of cases seen at the clinics in the sub-districts are sent to the bio-statistician. Diagnostic categories on which data is collected are acute psychosis, substance abuse, epilepsy, neurosis, depression, mania, bi-polar affective disorder and schizophrenia, however these are not systematically collated.

One district health manager admitted that the true extent of mental health problems in the district is unknown, hence there is no data on which to base the planning of mental health services. She proposed a collaboration with the various stakeholders in the district from the District Health Directorate to the religious leaders, to work together to identify the extent of mental health problems in the district and to promote mental health:

> *'I think mental health in the district deserves a lot of attention. So I think at the district level maybe the District Health Directorate has to champion the course to establish the mental health unit that can function very vibrantly to be able to track a lot of the mental health cases. Then also be able to give the necessary health education that is required for prevention purposes, just as other preventive campaigns that are going on. So I believe the District Health Directorate has to take that leading role, maybe through that, they can assist to get the hospital one established.'*
> *(Respondent 59, health manager, district level)*

District hospital

The district hospital in Kintampo town has 64 beds and provides emergency services for all surgical and medical cases in the district. It also acts as a referral centre for cases from the community clinics and health centres and provides antenatal care and supervised delivery, paediatric care, some elective surgery and specialist outreach clinics e.g. ophthalmic services. The hospital functions as a primary care facility since many people self-refer at the Outpatient Department for consultation with the doctors and medical assistants who hold daily clinics. Cases which require specialist assessment are referred to the Catholic hospital in Techiman or to the regional hospital in Sunyani.

There is one Ghanaian doctor working in the district hospital, who serves as the medical director, and two Cuban doctors provided under a special agreement with the Cuban government, paid for by both governments. The hospital has close links with the adjacent health research centre and Rural Health Training School. Some doctors from the research centre provide clinics and conduct trials using the hospital population, and medical assistants and other trainees from the training school, such as laboratory technicians, also undertake their practical attachments at the hospital.

There are no specialist mental health professionals working in the district hospital, however one of the medical assistants formerly worked as a psychiatric nurse and psychiatric cases are usually referred to him for assessment and treatment. Staff at the district hospital try to manage those who present at the hospital with mental health problems with the few available resources, including limited supplies of psychotropic medication:

> *'We try to manage when they come with the very little that we have…. Actually we don't have many of the drugs used in managing mental health, we have very few of them available. Anti-depressants, they have to buy from outside. We do take care of people who are depressed, we do take care of people who have abnormal behaviours, acute psychosis, we try to handle them, and then when we are not successful…. but actually we don't have enough facilities, the human resource base, we don't have enough to be able to handle psychiatric conditions.'*
> *(Respondent 74, senior health worker, district hospital)*

Primary Health Care Clinics

There are 2 health centres and 2 rural clinics in North Kintampo district, as well as 2 private clinics. The clinics are staffed by community health nurses and community midwives. There are no doctors working in the clinics. In addition there is one outreach office staffed by 2 technical officers, and I CHPs compound staffed by a field technician.

The adjacent Kintampo South District has 5 clinics, one of which is being upgraded into a district hospital.

Community Health Workers

There are 4 Technical Officers and 9 Field Technicians working in public health in Kintampo North district. They work predominantly in community surveillance, disease control and immunization. There are 2 volunteers working under the CHPS programme and an unknown number of community-based surveillance volunteers (CBSVs).

3.7.1.2 Government sectors

The district is divided into 6 town councils, 1 area council and several unit committees for administration and governance. The administrative body is the District Assembly which comprises 69 members. Most assembly members are elected by the communities, but some are appointed by central government. They serve as a direct link between the chiefs and people of the communities. The District Assembly oversees the Community Water Supply, Civil Education and Agricultural departments, as well as private health facilities, and thus plays a key role in public health and health promotion.

3.7.1.3 Other community health institutions.

The Rural Health Training School

The Rural Health Training School was established in 1969 and is currently the national training centre for middle level public health professionals such as technical officers and field technicians, who identify common diseases for referral and/or treatment, thus preventing disease complications and mortality at the community level. The school also provides training for medical assistants. Students and staff can serve as a resource in immunizations, disease case detection and health education through role-plays and health talks at the community level.

Kintampo Health Research Centre

Kintampo Health Research Centre (KHRC) is one of the three health research centres under the Health Research Unit of the GHS. The research centre conducts operational and experimental studies that inform health policy and programmes within the Ministry of Health and GHS. Current research is predominantly in the areas of malaria and maternal and child health.

A mental health research team has been established at KHRC led Dr. Victor Doku, a Ghanaian psychiatrist and epidemiologist who conducted an epidemiological study of psychosis in the area (2002-2005).

Kintampo Demographic Surveillance System

Kintampo DSS is a member of the international INDEPTH Network of field sites in developing countries employing the Demographic Surveillance System (See chapter 2).

3.7.2 Knowledge of Mental Health Legislation and Policy

At the district level most respondents had very limited knowledge of the provisions of the mental health decree and mental health policy. As the following quotations reveal, many of the respondents within the health service said they had no idea of the existence of these documents, let alone awareness of the provisions of mental health legislation and policy.

> *'They haven't even circulated it for us to see.'*
> *(Respondent 62, senior nursing officer, district level)*

> *'I haven't even heard of the mental act.'*
> *(Respondent 80, medical doctor, district level)*

> *'I haven't seen the policy, but it's likely that the policy is there but its*
> *implementation is the problem.'*
> *(Respondent 62, senior nursing officer, district level)*

> *'I think that policy must be made available for all of us…..'*
> *(Respondent 62, senior nursing officer, district level)*

Some respondents demonstrated some awareness of the provisions of the mental health decree regarding criminality and mental illness. However with virtually no knowledge about the existence and provisions of the mental health decree and policy, respondents were unable to provide information about professional input, training in the provisions of the policy, the impact of the decree and policy on work

performance, whether the legislation and policy are being implemented, and whether there is a need for change in some of the provisions of the legislation and policy.

3.7.3 Common and serious mental health problems

3.7.3.1 Training

Staff in the district health facilities reported receiving no training in mental health other than what they had received during their basic training. Health workers expressed a need for training to enable them to work more effectively with mental health patients who present at primary care facilities:

> *'I believe all the nurses require training, all the nurses, doctors, and medical assistants who mainly come into contact with these people require training to provide care to them, as well as those at pharmacist level, they also have something to do with when it comes to administering drugs for mental health.'*
> *(Respondent 59, health manager, district level)*

> *'It is a challenging area and if I have the opportunity I think I would want to go into mental health, because we have to refer so many people with mental illness to the regional hospital. Some end up not going,....some even ask us to discharge because they think is a spiritual.....That training, if I have the opportunity to go through mental health education I will appreciate it.'*
> *(Respondent 74, medical doctor, district level)*

3.7.3.2 Supervision and support

There are no structures for supervision and support for those who work with cases of mental health in the district. One respondent attributed this to the fact that mental health is not a priority in the district compared to other health concerns:

> *'Actually mental health at the district is not been given the needed support, the needed recognition at the district level. So unlike antenatal, postnatal, children under five years, they are always*

highlighted, mental health has not been seen as a priority area in the health delivery, and because of that, support is not… there is no such support in mental health.'
(Respondent 74, medical doctor, district level)

It was suggested that the regional psychiatric unit could provide support for mental health care in the form of outreach:

'I think regional support should come in the form of the outreach services that the psychiatric units….. I believe there should be a programme like that even though we don't seem to see much of that happening at the district level. But they are supposed to have an outreach plan for each district so that from time to time the psychiatrist will visit maybe a community together with the psychiatric nurses, maybe, to see cases that exist in the district. So I believe that support should be in the form of outreach services to areas that do not have this community psychiatric service available.'
(Respondent 59, health manager, district level)

3.7.3.3 Referral

In Kintampo North and South Districts there are currently no practising psychiatric professionals. A doctor with a year's postgraduate training in psychiatry is based at the psychiatric unit at the regional hospital in Sunyani, about 3 hours' away by public transport. The unit has 22 short-stay inpatient beds and 4 psychiatric nurses. There is also a volunteer with training in psychotherapy working at the unit. Two CPNs are based in Techiman at a distance of around 45 minutes by public transport. The CPNs have no funding for transport and so rarely conduct outreach visits to patients' homes.

All psychiatric cases needing specialist assessment and treatment are supposed to be referred to the psychiatric wing at Sunyani regional hospital, however in practice some are referred directly to Ankaful psychiatric hospital near Cape Coast, approximately 8 hours' journey from Kintampo. The health care worker at the district facility is expected to provide a written referral letter to accompany the patient, outlining the patient's presentation and medical history and any tests or treatment

undertaken. This is given to the patient to take to the psychiatric facility. Whilst referrals can be made to the CPN in Techiman for community support and treatment of the mentally ill, this appears to be rare. Due to lobbying by a mental health researcher there are plans for a CPN to be transferred to Kintampo in the near future.

> *'At present we don't have a psychiatric nurse, so we usually admit them briefly and then we try to find out the cause. Those that we can handle we give counselling and then we treat effective causes of mental illnesses, and then we refer to centres where they have psychiatric nurses [….] But we are planning to lobby for psychiatric nurse because of late we are getting many of such cases.'*
> *(Respondent 74, senior health worker, district hospital)*

Agitated or violent patients who present to the clinics and hospitals are given sedating medication, such as Largactil, and then referred to the hospitals:

> *'If someone is sick in the community, they will first report to the primary health worker at the health centre. So if the person is very rowdy or very violent the worker may give Largactil to calm him down and then refer to the hospital. Then they bring the person to the hospital, the doctor will look at the drug that was given, if it can still maintain the person calm then they will also refer to the next level.'*
> *(Respondent 62, senior public health nurse, district level)*

There is very little support for families to escort patients with mental illness to the psychiatric facilities once they are referred and they are usually reliant on public transport, even when the patient is very disturbed. An ambulance has recently been donated to the district hospital and hospital staff reported that this could be used to transport psychiatric patients to the regional hospital. However relatives were often unable to meet the cost and preferred to go by taxi. This means that a nurse was rarely able to accompany the patient to the regional hospital:

> *'The ambulance is available to any form of service, that is certain about it. The only problem is that when the relatives are asked to give money for transportation, they would turn and go to town and*

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go to pick their own vehicle because the cost involved here is
costing more than the other…, it will be expensive. So they rather
prefer going to town to pick their own vehicle and go. And that you
can't get a nurse to follow up to wherever they are going to because
I don't think a taxi can accommodate more than six people to carry a
mental patient to wherever he or she is referred to.'
(Respondent 85.4, nurse, focus group discussion, district hospital)

Although there is supposed to be a procedure for feedback and back-referral to the district facilities for follow-up once the patient has been discharged from the psychiatric hospitals, it was reported that in practice this seldom occurs. It is generally left for the patient to return to the regional or psychiatric hospital for review or to attend the district hospital for medication:

'Ideally, we should always be given the feedback, but unfortunately,
that is not the case for all the referrals we write. So far we don't give
feedback…. I mean, we don't get feedback…… I think it is the
workload.'
(Respondent 74, medical doctor, district level)

Health care workers expressed the need for the development of mental health services in the district. Several felt that Kintampo should have its own psychiatric services and professionals, especially given its geographical position in the centre of Ghana:

'….I think it will also be necessary that such facilities or such trained
personnel are also put here [Kintampo], *[….] But Kintampo has*
grown and is very, very noted for medical institutions in Ghana and
we also need such facilities here. We need such caliber of
personnel who will handle such issues. At least being the centre too,
people even from the north can also benefit. Those very close to us
too can also benefit. So I think is very, very important that maybe
the institutions or the government institutions should do well to
support even the training of such personnel.'
(Respondent 66, senior police officer, district level)

3.7.3.4 Treatment protocols

Staff at the hospital and clinics have access to the Standard Treatment guidelines produced by GHS which include treatment guidelines for the major psychiatric conditions such as schizophrenia and depression (Ghana Health Service 2004b). Staff also have access to the Ghana Essential Medicines List (Ghana Health Service 2004a) and sometimes a copy of the British National Formulary.

3.7.3.5 Psychotropic medication

Respondents indicated that there is some psychotropic medication available at the district hospital but supplies are often not sufficient. Available psychotropic drugs at Kintampo District Hospital are: Chlorpromazine, Amitriptyline, Haloperidol, Diazepam and Carbamazepine. The medical store for the region is also located in Kintampo and CPNs from Techiman and Nkoranza requisition supplies from here. The above mentioned drugs are available from the medical store as well as Olanzapine. However there are sometimes problems of supply, leading to shortages of some medication. Psychotropic drugs are provided free of charge.

3.7.3.6 Budget

There is no dedicated budget for mental health at the district level. This means that the ability to plan for the care of the mentally ill at the primary care level is severely constrained:

> *'We just do within our reach, whatever we can do to help the people. The budget is not enough and you cannot come out with specific programme. That is the limitation because we don't have an earmarked budget, even what we have, it is too small. So we cannot do more than we are doing now, and is even worse because there is no one who is responsible for that aspect on the team.'*
> *(Respondent 62, senior public health nurse, district level)*

This respondent also suggested as did others quoted above, that with greater resources, primary care staff could organise training and provide educational programmes on mental disorders on local radio.

It was also stressed that if more resources were made available, the quality of care rendered to psychiatric patients would be improved, and a psychiatric wing could even be attached to the district hospital.

3.7.3.7 Language

All the Ghanaian health professionals in the district speak at least one of the vernacular languages, including Twi, as well as English. The Cuban doctors at the district hospital speak English as a second language and communicate with non-English speakers via the nurses or nurse aids who provide interpretation. There are no specialist trained interpreters. When the clinician and the patient do not share a common language, family members are commonly used as interpreters:

> *'….most of the time we try to get relatives who can speak the same language with the victims; then they can interpret in other languages. If it's English or Akan language I think most of the times there are some relatives who are able to understand and they can interpret. If it is not even a close relative but if the person's tribe is identified, there may be a way of getting somebody who speaks the same language to assist us..'*
> *(Respondent 59, health manager, district level)*

Language barriers were not generally seen to be a problem because of the ease of finding someone to translate, however one clinician admitted that:

> *'If you cannot speak the same language with the person its difficult to get actually the correct history and development of how the illness starts. So it is a barrier even in diagnosing the particular mental health.'*
> *(Respondent 74, medical doctor, district level)*

The high levels of illiteracy in the area, particularly among women, mean that access to health information is limited for those without the ability to speak and read English. Clinical notes and prescriptions are recorded in English in the clinical facilities and all notices and signage in the hospital and clinics is in English, including the Patient's Charter. Community radio provides some health information in the vernacular languages.

3.7.3.8 Children and adolescents

There are no specialist services for child and adolescent mental health at the district level. The DMHT sends workers into the schools in the district to conduct physical examinations and sight and hearing tests. Health education is also conducted in the schools, and includes education on drug abuse. Children who are suspected to have been sexually abused are referred to the police, who then request a medical examination and refer to Social Welfare and WAJU. Primary health workers who encounter children with psychological problems or developmental delay usually refer to the district hospital, who then refer to the psychiatric hospitals if specialist assessment and treatment is deemed to be required. Parents will also bring children with developmental delay or abnormal behaviour to the district hospital for consultation.

3.7.3.9 Programmes for mental health

There are no specific programmes for mental health promotion in the district, although one participant suggested such programmes might be carried out as part of the general public health education through radio programmes, durbars and talks at the schools, churches and mosques:

> *'I think there are educational programmes that go on from time to time through the public health unit in the district. Usually they carry out health talks on the air, and when they go to the communities, at durbars, sometimes they will talk about programmes to educate people, maybe substance abuse and other problems that can lead to these mental health problems. So I think there are programmes*

like that as part of general public health education that is carried out.'
(Respondent 59, health manager, district level)

Apart from occasional discussions related to substance abuse, there are no mental health programmes for vulnerable groups such as women or children and adolescents. However one public health nurse reported that mental health promotion is included within antenatal classes for women. This includes advice on marital relationships and childcare, especially for teenage mothers:

'….mental health can be triggered off by marriage problems and things like that and when we talk to the women in groups that we meet we talk about how they should cope, the relationship between they and their husband, the type of food they should eat for the children to grow well both in the tummy and when they are out and born, and all these we believe contribute to a successful marriage and some of them are able to cope. We don't tell them like if your husband does these you have to also get annoyed, you have to be calm and then of course you should know the man is the head of the family and if you respect the man, the man will respect you. If the man doesn't have money and you have money that day you also cook, and all these things, try to bring peace into the house and then less stress on the woman. Especially the teenager who has no husband, we visit them in the home, we try to let their parents accept the girl that way, they should try and support, these are some of the things that we are doing.'
(Respondent 62, senior public health nurse, district level)

3.7.3.10 Explanations for Mental Health Problems

The respondents at the district level showed varying degrees of knowledge about mental illness. Respondents saw mental illness as a disorder that has physical, spiritual and mental connotations. Some located mental illness in the mind. One member of the police talked about the mind as 'the engine of the body':

'Yes, as he said, mental illness is when the mind…when somebody has developed a mental problem thus his normal behaviour, how he behaves, how it is has changed. When the mind has changed you see the whole body looks otherwise.'
(Respondent 87.1, police officer, focus group discussion, district level)

Other responses stated that mental illness has to do with behaviour which is inconsistent with societal norms:

'Mental illness comprises all forms of psychiatric disorders characterized by abnormal behaviour, then social ineptitude…people behave differently from societal norms…'
(Respondent 74, medical doctor, district level)

'Mental illness is simply behaving abnormally. Behaviour which is not related to normal accepted behaviour in the community.'
(Respondent 82.1, teacher, focus group discussion, district level)

'A disease which affects the mental being of the individual when the person cannot analyse or perceive things the normal way'.
(Respondent 80, medical doctor, district level)

Some related mental illness to stress:

'I see it from a point like someone who is not able to withhold…has a very low threshold for events relating to stresses in the environment.'
(Respondent 85.3, nurse, focus group discussion, district level)

Mental illness was classified by one teacher as a spiritual sickness:

Respondent: 'I think some of the mental problem is not just mainly poverty but at times it can also be this spiritual kind of sickness, maybe spiritually you are been controlled by some kind of spirits that forces you to do things that are abnormal you don't actually think of

doing but the spirits in you controls you to do what is not accepted in society.'

Interviewer: 'What are you calling spirits?'

Respondent: 'Looking at the mad people in town they see things that we don't see, they talk with things that…hear voices that we can not hear, so I think those things are spirits following them.'

(Respondent 82.5, teacher, focus group discussion)

3.7.3.11 Causes of Mental Illness

Several causes of mental illness were described by respondents at the district level. These included poverty, unemployment, marital or family problems, hereditary factors, accidents, early childhood physical and psychological maltreatment, and stress and frustration. The following were representative of such responses culled mainly from focus group discussions with various professional groups:

> *'Some of them when they lose their jobs it plunk them into mental problem. Some of them too, maybe she has been raped and too much thinking on that can lead to mental problem. Some of them too it is genetic, he was born with it. It means the illness is in the family. Maybe somebody from the family has gone to seek the assistance of gods and did not fulfil the promise. So anybody born in that family is covered under that covenant.'*
> *(Respondent 75, Muslim healer, district level)*

> *'Frustrations can also cause mental illness. Like for instance I want to go outside and I invested a lot of money in my visa and finally when I get to the airport or the ambassador then they disappointed me, or sometimes I can get to the country and then they deport me. That one when I come back I am going to be frustrated and that one can cause this thing.'*
> *(Respondent 83.9, teacher, focus group discussion)*

> *'Sometimes too stress, too much stress on the body. Sometimes too you may…especially when you are at work your boss will be*

expecting too much from you which you cannot do. In that case you will become so depressed and so depression can easily lead to mental illness.'
(Respondent 83.2, teacher, focus group discussion, district level)

Respondents also identified several 'cultural' or 'spiritual' causes for mental illness, including witchcraft, curses, flouting taboos and traditional practices:

'.....there is the belief that, sometimes when you go against certain people they can curse you. For a man has gone in for another man's wife, you can be cursed and you can be mad. If you steal certain things belonging to the family in our Akan area there are some people who we hear they are mad because they had stolen gold belonging to a particular family, when you do that you are cursed and you become mad.'
(Respondent 84.3, teacher, focus group discussion, district level)

'..... culturally, we have our traditional festivals, shrines, stool houses, and it is believed that the young children during festivals, those who carry shrines and then the stools to shrine houses, such children finally develop mental problems. When they have festivals, they have shrines, they carry them to stool houses and you see young, young girls are carrying these things. In the end, such children who carry such stools and shrines, they develop mental problems. The priestess, we have fetish priest, children take part in sacrifices at these shrines, in the end, they become mentally disturbed. So culturally yes, there is a link between cultural practice and mental problems.'
(Respondent 84.9, teacher, focus group discussion, district level)

'There are some people traditionally who are linked to a certain deity and for that matter they are supposed to behave in a certain way. So that when you deviate in that kind of behaviour after series of warnings you are punished, and most of the time the punishment takes the form of mental illness. You begin behaving strangely, and at the end your condition has to be dug into for you to realize that

they are allegiance to this deity which you have sort of broken. That
can also cause mental problems.'
(Respondent 84.6, teacher, focus group discussion, district level)

Some attributed mental illness to alcohol abuse and the use of narcotic drugs, in particular 'wee' (cannabis):

'These days what do we see? Our youths, what do they indulge in?
They indulge in drugs, drug abuse and definitely the cause might not
be from the home but peer pressure. Through peer pressure at the
secondary school level, now even at the JSS [Junior Secondary
School] *level, we have children smoking 'wee' at the JSS level, and*
definitely they are leading themselves into mental difficulties.'
(Respondent 60, education service, district level)

'Nowadays, the young men and women that are suffering from
mental illness are as a result of 'wee' smoking, use of hard drugs,
and alcoholism.'
(Respondent 70, pastor, faith healing church, district level)

3.7.3.12 Attributions of Users

Few interviews were conducted with users of mental health services, therefore there is limited data on users' attributions of mental illness. Those interviewed suggested a mixture of social and spiritual causes of their illness:

Interviewer: 'So what do you think causes that? What makes you to
do that?'
Respondent: 'It is a depression, depression or frustration.'
Interviewer: 'Why do you think you are frustrated?'
Respondent: 'Because of my husband, the way he handled me.'
Interviewer: 'So you are thinking that it has been caused by the way
your husband…?'
Respondent: 'The way my husband treated me.'
Interviewer: 'Do you think there is any other possible cause?'

Respondent: 'No, in my village they say they are with the stool [traditional seat of chiefs], we are king makers, so we have to perform some customary rites. This is what the elders are saying, but to me, I know I have to take my medicine.'

(Respondent 76, user of psychiatric services)

Interviewer: 'What do you think is the source of your illness?'
Respondent: 'I believe it is from one pastor who administered a nasal drop to me. I became drowsy and my mind became abnormal'
(Respondent 77, user of psychiatric services)

3.7.3.13 Gender and mental health

Gender correlates in mental illness were expressed by many of the respondents. Both male and female respondents felt that females were prone to mental illness due to marital conflicts, the domineering role of men in society, the burden of childcare, and domestic violence:

'….when you look at the gender perspective, women by their make-up sometimes are easily prone to psychological torture than men. When it comes to issues about marriage problems, or inability to get husbands, some eventually go off as a result of intense psychological trauma. So I think gender plays a part because women are usually considered as a weaker sex, they are not empowered enough to be able to enjoy their rights in most cases, and sometimes some are suppressed and out of frustrations. So gender plays a part.'
(Respondent 59, health manager, district level)

'…some women become mentally disturbed as a result of marital problems. When they are with the men alright, and all of a sudden the men begin to jilt them, begin to see other women, and then forget about them, they think of them, and then they develop mental problems..'
(Respondent 84.3, teacher, focus group discussion, district level)

Interviewer: 'Now do you think there is any link between gender and mental illness?'

Respondent: 'Yes, you see our African men, our traditional way of marrying, sometimes, you marry about three women and then yon may neglect the other one, then you will start thinking. Or she is the only wife but the husband may not pay good attention and may be moving with other women and that may lead to mental illness because majority of the cases come from this point.'

Interviewer: 'You think there are more women with mental problems?'

Respondent: 'Yes. You see the women needs love, so if you don't provide the love and you turn away from her, going from one woman to the other, then they will start thinking and then hysteria will set in, and then it can lead to the mental problem.'

(Respondent 67, health worker, district level)

The burden of childcare was seen to fall on women putting them at greater risk of poverty and mental health problems:

' You know normally when you talk of poverty, the woman…. the children are on her side [under her care]*, even though the man is supposed to be remitting, when the man is not having everyday* [has no source of income]*, he will go away and then because of the poverty, the children will be crying on their mother and see that she will not have a sound mind and as a result create mental problem.'*

(Respondent 64, Social Welfare department, district level)

Other respondents expressed the opinion that men are more at risk of mental disorders through the abuse of alcohol and drugs:

'But when it comes to men it originates from drugs. Very many of the men they become mad as a result of intake of hard drugs.'

(Respondent 84.3, teacher, focus group discussion, district level)

Men were also perceived by some respondents to be at risk of mental illness when they failed to succeed in their ambitions, such as emigrating abroad:

> *'They are a lot of them, when men travel to seek greener pastures and they don't succeed it brings about this mental problem.'*
> *(Respondent 75, Muslim healer, district level)*

Several respondents saw women as more vulnerable to stress and depression, and related this to disappointments in love and marriage, a kind of folk diagnosis called "broken heart". Men were seen as more prone to obvious forms of madness like psychosis, often related to drug abuse. This perception of gendered forms of mental illness is exemplified by this police officer:

> *'Women too, when they are turned down in love, it lands them a lot. So even when you go to this psychiatrist, they used to say it there, some of them is just "broken heart", many of them. But you see, when woman divorces a man suddenly it doesn't normally affect the man too much. But as for men before you see it is the marijuana, that is the drug. Many of them … so the drug rendering you to mental illness that one is different from other mental illness. As for that one it's a drug, but normal mental illness is the women. They don't normally take drug, but many of them are in the psychiatrist, immediately you fail them small then they become dejected.'*
> *(Respondent 87.2, police officer, district level)*

Respondents suggested that empowering and educating women and supporting them to exercise their rights was one way of helping to prevent mental health problems amongst women:

> *'I think women must be empowered and encouraged to enjoy their rights to the fullest maximum, and be given the necessary assistance particularly to ensure that they are able to exercise their rights and stay away from maltreatment from their male counterparts. I think they also need to be educated especially when it comes to marriage issues, a lot of education will do, so people will understand each other and not get frustrated and eventually grow mad.'*
> *(Respondent 59, health manager, district level)*

3.7.3.14 Mental Health and Poverty

There was a great deal of agreement among the respondents at the district level on the links that exist between mental ill-health and poverty. Many respondents indicated that poverty could induce all sorts of mental problems including stress, depression and anxiety:

> *'Yes, mental health and poverty, poverty can lead to mental illness. That is, if you have no money on you, even now as you are sitting down now, if you have no money, you will be so depressed, you will be worried, somebody will be talking somewhere, even you will be annoyed because you are depressed you don't want to hear that "noise".'*
> *(Respondent 85.1, nurse, focus group discussion, district level)*

> *'....when we look at mental illness as a form of ill adjustment to stresses, then you see that money or poverty has a problem there. Somebody cannot afford three square meals or just one meal and he sits depressed, is a form of mental illness. And so you can see a practical display of poverty there.'*
> *(Respondent 85.3, nurse, focus group discussion, district level)*

> *'Picking from the cases that we had always had here, you try scoring from their background: they come from poor backgrounds,* [the] *few cases we had to refer, manage and they had to carry away or manage and failed. they always come from poor family economic background. We have never had a case that comes from a well-to-do background. From the few circumstances they become wretched and dirty and you can just picture that they are from poor family background.'*
> *(Respondent 85.2, nurse, focus group discussion, district level)*

> *'Poverty can make someone develop mental problem. If you are very poor, whenever you are walking, you will be talking to yourself like a mad person. So it is very true that poverty and mental problem have some relationship.*

(Respondent 86.5, traditional healer, focus group discussion, district level)

Several respondents suggested that poverty resulted in the person 'thinking too much' or 'excessive thinking', and this could lead in turn to physical health problems such as hypertension as well as mental illness or madness:

'…poverty brings depression and other problems and you need to survive at all cost. You can't have the basic things, you get to worry, and too much of thinking brings in a lot of things like high tension and high blood pressure, all these. For if they continue, some of these conditions will lead to mental health problem.'
(Respondent 84.1, teacher, focus group discussion, district level)

'You know if you can't meet certain basic requirement, you are not able to pay your bill and look at the family properly, okay, if you don't have a family, you look after yourself properly to settle, at least the basics, it sets you thinking, like madam said, the brain is designed to take some amount of pressure. If it exceeds it, it breaks it down and that will lead to mental problems. So a healthy brain depends on a healthy pocket.'
(Respondent 84.6, teacher, focus group discussion, district level)

Poverty was also linked to poor nutrition which was seen to result in damage to the brain which could lead to mental illness:

'And too from infancy, we know that some foods are there when you take it gives us strong mental development. So because some families, they are so poor that even what to eat… even the nutrition that people need for mental development they don't have. So that one too you see, some one will grow up and develop a mental problem due to poverty. So poverty has a strong influence on mental problems.'
(Respondent 87.1, police officer, focus group discussion, district level)

Some suggested the effects of poverty such as hunger and overcrowding, could lead people into abusing drugs or alcohol which in turn could lead to mental illness.

> *'People who are poor are likely to go into this alcohol, these drugs. Is funny, I heard over the radio sometime ago that, we observe that those in the north, we those in the north or the north, a lot of people are smoking these cigarette, a lot, and we know that north is also a deprived area, people are poor and there is that report that, the north there is high alcohol intake too. So sometimes people are taking those things to forget about their problems, or the stomach is making noise, oh you take a little, and then maybe it subsides for you. So there is that linkage between poverty and mental health.'*
> *(Respondent 84.5, teacher, focus group discussion, district level)*

> *'….now if you go into our community, the people are poor, they are farmers, they want to produce more, and in their effort to produce more, they go about taking drugs that will enhance their strength to make them work harder, and what do we end up with? Cooking and drinking marijuana. Now people are poor, they are not able to accommodate their children properly because the person is poor and hire only one room, the children are many, and so what happens is that, when the parents are at home and want to have sex, the children have to stay outside for some time before they are allowed in, and when they are outside other colleagues are around and before you realize they have formed a gang and they are introduced to drug, if not alcohol, this drug they call like these "volume ten" and the* 'wee'*.'*
> *(Respondent 62, senior public health nurse, district level)*

Respondents had to be prompted to discuss the reverse process, of mental illness resulting in poverty. However respondents recognised that mental illness affected the capacity to work, organise one's time and provide for the family:

> *'Yes it is, in that, somebody is well to do and all of a sudden, he becomes mentally sick, now he cannot work, and he cannot think properly and cannot control the family, he doesn't recognize his*

surroundings therefore he is going to be wretched because how he put things in order to work and earn, or to work and gain that money is no more there. Therefore the entire family, I mean the nuclear family is going to be poor.'
(Respondent 85.1, nurse, focus group discussion, district level)

'You need a sound mind to coordinate your daily events, so once you develop a mental problem then it is certainly sure that you can not coordinate your daily events. And so if the daily events brings in income to run the family's business and your own business and your normal life, then it tells you that there would a break in the flow of income and certainly once the breadwinner of the family... then the family is certainly going to change in terms of economics placement.'
(Respondent 85.3, nurse, focus group discussion, district level)

When the issue of breaking the link between mental ill-health and poverty was discussed, many of the respondents were of the view that government policies should address the root causes of poverty in the rural communities through supporting the poor in employment and income generation. Some respondents suggested that youth unemployment could lead young people into drug abuse with subsequent mental health problems and suggested skills and entrepreneurial training for young people in order to assist them into work:

'I think that this one, a lot will have to depend on the commitments of policy makers to come out with policies that would be geared towards tackling the root courses of poverty in the society. So the government must come out with programmes that will encourage people to go into acquisition of skills that will make them employable. Support in terms of maybe loans and other schemes to engage people in economic activities and business ventures. The government can do a lot in that direction.'
(Respondent 59, health manager, district level)

'After they have been healed, if the government assists them to get jobs, it will help them a lot by not letting them think so much, poverty is madness, so if they get jobs, it will help a lot.'
(Respondent 70, faith healer, district level)

'Some become mentally ill because they are poor, so if they are given money to trade, to make a living, they can be sound.'
(Respondent 87.2, teacher, focus group discussion, district level)

3.7.3.15 Stigma

Many respondents at the district level spontaneously mentioned the stigma attached to mental illness. Respondents were almost unanimous in the view that as soon as you develop mental illness, you no longer have any worth in society:

'When you are mentally ill in Kintampo district, I think it's also applied to other districts, you will become a social outcast. People point accusing fingers at you, you see, there is no gathering you will go and people will accept you. Immediately people pronounce you that you are mad and you come there they fear that this person can be very dangerous to our health, we must do something, he can relapse. So they will say: "Go, go, go, stay aside in that order". So people perceive people who're mad as not part of the society.'
(Respondent 15 senior officer, mutual health insurance scheme)

'And the stigma attached to mental illness now in our society is such that, no matter what you should be when you are said to have mental problem then the society attaches that tag to you and you can't be that important. Once you are coming in, people will start moving away, is like your contributions cannot be valid even if occasionally they are. They shun your company.'
(Respondent 85.3, nurse, focus group discussion, district level)

This is even the case for those who have recovered. The stigma is maintained by the belief that once you have developed a mental disorder there is always the tendency

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to relapse. It is commonly believed that there is no complete cure from mental illness, and that sufferers are left with residual symptoms for the rest of their lives:

> *'…you see it is very rare cases that mental illnesses are actually cured completely. Most of the time people end up spending their whole life in the mental institution or on the streets, so that even if you're cured like he said, you can still come back to your previous condition'*
> *(Respondent 84.6, teacher, focus group discussion, district level)*

> *' I think sometimes subjecting yourself to mental treatment in public mental hospitals is sometimes not very accepted because even after recovering from your mental illness, if you say something factual in society that the society is not interested in, they subject you to your previous mental illness. So certainly we are not treated the same, even those who recover still have the consequences to face.'*
> *(Respondent 84.2, teacher, focus group discussion, district level)*

This means that it is difficult for those who have or have had a mental health problem to marry or find employment:

> *'Then the brain is like the engine of the body and somebody who has a problem in the brain if you marry such a person, how can the person raise children? How can the person work and then take care of the house? So if you are in the society and you want to marry somebody with a mental problem I don't think your people will accept and I don't….. I have never seen, I have never heard of somebody who has tried to marry somebody with mental problem before because it will not work, you can't reason well, and if you can't reason well as a human being how do you raise a family? So I don't think it will work…..'*
> *(Respondent 83.7, teacher, district level)*

> *'….traditionally before you marry they have to study the family background, if they hear that there was madman in the family, you will never… they couldn't allow the girl to marry from that family.*

So there is discrimination. The family may want to get him a wife but they will investigate and find out that "No, this family there is danger" …..So there is discrimination.'
(Respondent 84.9, teacher, focus group discussion, district level)

'The fact is that, if the sickness prevails, or still you are not fully recovered, definitely you yourself will not be able to do any work normally. Apart from that, if the patient recovers at all, there is a fear that there may be a relapse, and imagine, with a very serious document, and there is a relapse and he messes up the whole thing, because of that…, and your output as well. The productivity may be so low that if you have to be paid according to the productivity, you may not be willing to take up the job.'
(Respondent 84.4, teacher, focus group discussion, district level)

People with mental illness were also reported to be excluded from important aspects of family life in Ghana such as 'family meetings':

'….and if you are in a family too and you develop such a… when even the family meet for some discussion at times even they don't call you. At times when you come there yourself, they persuade you: "Okay, you go and sit down", they always want to hide some important things from you.'
(Respondent 87.2, police officer, focus group discussion, district level)

Mental illness is often associated with violence and unpredictability which was given as another reason why one would not want to marry or employ someone with mental illness:

'I want to add that stigmatization and fear, the fear……Members fear stigmatization, and the work place, they fear that the mad person can explode at anytime. So for fear of employing the person and family members, they don't want people to know that their member is mad so they even don't want him to even go out of the house whether for employment or not, they wouldn't want him to go for that employment for fear of social stigma, and at

> *work place, nobody want to employ a dangerous person, someone*
> *who can explode at any time.'*
> *(Respondent 84.9, teacher, focus group discussion, district level)*

> *'Because of the nature of the sickness, when somebody is*
> *mentally ill the fellow can easily take a cutlass and kill you, so if*
> *you go and marry such a person, you are risking your life, you can*
> *die out of that. So that is why they don't.'*
> *(Respondent 83.2 teacher, focus group discussion, district level)*

Several respondents mentioned the extension of the stigma to those who work in mental health facilities. This perception stems from the belief that madness is "contagious" and that those working with people suffering from mental disorders can themselves become "tainted with madness". This perception is not only held in the general population, but also by health professionals:

> *'In fact it has effect on them, because I know a psychiatric nurse*
> *who was my mate, he actually behaves like them. In the ward you*
> *see him pulling his tie and doing all sort of abnormal things. They*
> *actually behave like them.'*
> *(Respondent 85.1, nurse, focus group discussion, district level)*

Respondents suggested that education both for families and professionals who come into contact with the mentally ill was one way to reduce the stigmatization:

> *'I will wish for education for families to understand that when*
> *somebody is mentally handicap, that doesn't mean he is totally out*
> *of the family.'*
> *(Respondent 87.1, police officer, focus group discussion, district*
> *level)*

Another respondent talked of the need for 'sensitization' to increase awareness of the rights of the mentally ill across all sectors of society:

> *'…we need to sensitize the public. Sensitization, because people*
> *don't know even the right of the disabled or mentally ill people.*

> *There is also the need to address the target groups like school children because whenever they see them, they at times shout at them and doing something which also annoys them. The market women and the police all need to be sensitized. Then also if you want to go further the, GPRTU* [Ghana Private Road Transport Union] *for instance. So far as Social Welfare is concerned at times you may see those people, especially children with mental problem, and you like to help by sending them to the psychiatric hospital. So in such a way the GPRTU have to come in and help.'*
> *(Respondent 64, social welfare, district level)*

3.7.4 Government sectors

3.7.4.1 Education

Three focus groups were held with teachers from both private, religious and state schools, as well as interviews with two senior managers at the district office of Ghana Education Service (GES). The following analyses illustrate the perception that mental health and illness impacts on education and vice versa.

Causes of mental illness

Several teachers mentioned poverty as a cause of behavioural or mental health problems in children:

> *'….when you are poor, the family which you come from are poor. You are student - before you come to school you don't eat anything, so you are hungry, and even what you wear sometimes is not good enough. When you come you will sit down whilst lessons are going on you will be thinking, you will think, and you see the more you think the more you have problem in your brain. So poverty has a link.'*
> *(Respondent 83.7, teacher, focus group discussion, district level)*

Pupils who had little parental support, orphans, or those from 'broken homes' were identified as being particularly at risk:

'…maybe a child from a poor home who hadn't had much love or from a broken home who hadn't had that sort of affection at home, maybe through poverty the child has not been well nourished, that child may not be able to adjust properly when it comes to society. And therefore, in the school setting you will see that such children exhibit some sort of behaviours, first they don't want to share anything with anybody. Then secondly, they don't want to associate themselves freely with others, you would need really to coerce them to associate themselves.'
(Respondent 60, manager, GES, district level)

'So generally when we detect this thing there is a need for preferential treatment between that student who is mentally ill and the other pupil. For instance, in my class, I realize that, there is one girl and that girl, not that she is all that bad, when you look at the family background, her mother and father are all dead. So when the girl comes to school, you find out that she would be sleeping. And then when you are teaching in the classroom she doesn't concentrate. So in this case it's not her problem [fault]*, when you find such problem, you have to find a way to counsel such a child and some treatment. For instance, when she comes to the classroom for instance, she has no money to pay for the class fee. So there is no need that you all the time punish her for not paying, because naturally she is affected by the brain according to the circumstance of the environment, and lack of the parents. So there is preferential treatment for that particular girl in the class.'*
(Respondent 82.1, teacher, focus group discussion, district level)

' When it comes to the broken home, let's say your parents are not staying together, maybe you may be attending school in this place and your father or your mother is staying maybe at xxxx. Sometimes one of the parents may be aware that the child is with the father, meanwhile the father also knows that the child has informed him that he was going to the mother, and on the way this guy can definitely involve him or herself with any of the social vices which will generate in society madness and mental problem.'

The teachers also perceived drugs, particularly the smoking of cannabis ('wee'), to be a growing problem amongst students, especially boys, with consequences for mental health:

> *'And the boys too their problem is smoking sometimes. When the parents are not able to take good care of them they become too hostile that, they do whatever that they want to do. So due to peer groups and other things they get into drugs and then as they smoke and drink definitely their brains are affected.'*
> *(Respondent 83.7, teacher, focus group discussion, district level)*

> *'…normally you see more boys who are mentally deranged than girls because some boys…most of the boys go into drug abuse like smoking marijuana and drinking and all those things and that, leads to mental health problems.'*
> *(Respondent 69, headmaster, district level)*

One teacher suggested that the effects of poverty could lead a child to using drugs, in turn leading to mental illness:

> *'In our school system, when the child, a poor child cannot get dresses, he can't get shoes, even the exercise books, he comes to the class others make fun of him, he becomes a drop-out, indulges in 'wee' smoking and finally he goes mad. So it is because of poverty.'*
> *(Respondent 84.9, teacher, focus group discussion, district level)*

Some teachers also talked about poverty leading the female students into taking boyfriends who could be a source of financial support. Girls who then got pregnant at a young age were also identified as being at risk of developing mental health problems:

> *'And also the girls sometimes because of poverty the girl goes out to take a boyfriend, and then probably after pregnancy the boy denies*

you see, and because of the pregnancy the child may give birth and taking care of a child and herself becomes a problem and it is a severe mental problem.'
(Respondent 83.7, teacher, focus group discussion, district level)

Some teachers expressed fears about the safety of working with students with mental health problems, particularly if this was associated with the use of drugs, because of the risk of unpredictable and violent behaviour:

'..it is not safe to work with such people because the thing doesn't easily manifest itself sometimes. Something triggers off and anything can happen at that moment because there are some, who's are mild, but something very little can spark it off and anything can happen. So as a counsellor not less than five, six of them has passed through me for the past six years that I have been here [......].So it is not safe to work with such people.'
(Respondent 84.9, teacher/school counselor, focus group discussion, district level)

'Dealing with student who is expected to be taking, or believe in drugs is very dicey because of they way… because of the way… because of the effect of the said drugs on the person. So you might have sort of experienced such a situation before you can tackle the student. Now if you can't, you can refer to the school counseling system or other appropriate quarters. Since such students have violent tendencies, they can turn violent at anytime, it is a sort of aversive thing, you got to be very careful about how you tackle it and who you refer to if you can't tackle it yourself.'
(Respondent 84.6, teacher, focus group discussion, district level)

Services for children with special needs

Recently GES has begun to train experienced teachers as school counsellors. Counsellors were reported to be in place in most state schools in the district. There is a district coordinator at the district office of GES who identifies students with special needs, in particular mental retardation. The coordinator provides peripatetic support

to teachers in working with children with special needs, and makes referrals to medical services for assessment if necessary. If the child is found to be mentally retarded, the coordinator will refer the child to a special school if appropriate. It was reported that there are also occasional visits to the schools by the school health coordinator.

However one member of the education service highlighted the gap between policies and implementation in supporting children with special needs which means that some of the promised specialist support is not available:

> *'Government policies and actions, well policies are there but the actions are the problem. Because we have this constitution which gives the opportunity to everybody to be handled equally, but the actions sometimes…example: there should have been a good number of peripatetic teachers who should have been attached to the schools to help these children. Take them out during break and give them special tuition but this is not happening.'*
> *(Respondent 61, manager, GES, district level)*

Some reservations were also expressed about the quality of the training of school counsellors and whether they were really fulfilling their role in practice:

> *Interviewer: '……has the Ghana education got maybe any regular programmes to update people on behavioural problems, because these problems are dynamic, they can change?'*
> *Respondent: 'The counseling unit is supposed to do that. That is exactly what the counseling unit is supposed to do, but as you know, "no money syndrome", they don't do it. They are supposed to update the knowledge of teachers so that, they are able to identify some of the symptoms of deviant behaviour, symptoms of abnormal behaviour in class, the child may be too quiet, too aggressive, may be making noise, maybe not taking notice or sleeping, any other behaviour that isn't the norm in the classroom. So the counseling unit actually is supposed to be updating our schools every year, if not every term, but they don't do it. They don't actually come out to update the knowledge of teachers as regards to these problems.'*
> *(Respondent 84.9, teacher, focus group discussion, district level)*

Supporting students with mental health problems

When asked about how they would deal with behavioural problems or mental illness among their students, teachers identified three main courses of action. The first involved consulting the family to find out the cause of the problem:

> *'I think the first step is to find out a little bit… to find out a little bit more about the student in question and family background and things like that. These behaviors I believe don't just come out of the blue, something triggers them, either immediate or remote. So by digging into a bit of the student history you might come out with possible reasons for such behaviour, since, like I said, earlier they don't just happen, something triggers them to happen.'*
> *(Respondent 84.6, teacher, focus group discussion, district level)*

> *'When somebody is having a peculiar problem or attitude in the class which is not accepted, sometimes we get the headmaster informed, and if there is the need, we invite the parents to let the parents know the behaviour of the child in the class room. We compare the behaviour in the class room as to if there is some differences in his or her behaviour in the school and at the home so that the teacher will know if there is something wrong with him.'*
> *(Respondent 82.2, teacher, focus group discussion, district level)*

The second course of action was referring the student to the school counsellors:

> *'The Ghana school system now has a counseling department, yes, so probably one of the first things you may do is to examine the student critically and if you feel that he needs some counseling, as a sort of first aid, you refer him to the counsellor.'*
> *(Respondent 84.4, teacher, focus group discussion, district level)*

If teachers were unable to deal with the case through these measures, they would refer on to the district hospital:

> *' I also think that, when as teachers we notice such behaviours, the first point of call is to contact the parents to find out what is*

happening, the way he child behaves, and to know the group in which the child is moving. Sometimes, it could be that the child is on drugs, so when we contact the parents we will be able to know the sort of life the child lives in the house. If he exhibits the same thing then we can advise, if it is beyond control, then hospital has to take care of the child.'

(Respondent 84.3, teacher, focus group discussion, district level)

'And what we do is that, we keep on monitoring. Anytime the drug finish you see that the thing get worse, and they get on to the drugs it subsides. So we do a lot of referral cases to the hospital and also creating awareness, the parents together with the affected themselves.'

(Respondent 84.9, teacher/school counsellor, focus group discussion, district level)

Several teachers also mentioned making referrals to religious leaders such as pastors and imams. One school counsellor stated in the absence of support from central government, parents tended to seek the cheapest mode of treatment. As they may be required to pay for drug treatment at the hospitals, they might prefer to send the child to a 'prayer camp' or other place for spiritual treatment:

'I will say there is no support mechanism from the central government, we normally refer them. First of all we keep parents involved and we refer them … let the parent either take them to the hospital or the pastors too…if the school has a counsellor, to the counsellor, in fact it will come either from right from the classroom to the counsellor, and the counsellor if he cannot solve the problem, get the parents involved, refer the person either to the pastor, the Imam or the religious group, and the parents if they can send the person for treatment at the psychiatric unit. Some times these days they find it the cheaper way by going to prayer camps. Most of the times they go to prayer camps because they find it difficult to go to the psychiatric units. Some will go but they tell you: "They say the drugs are free, but you they say there are no drugs". They say: "When you go to Ankaful [psychiatric hospital] *drugs are free, and I took my child there, no drugs. They say I have to go and buy, so I*

brought him back to the prayer camp." So there is no support from
either the counselling unit, the central government or whatever
source, it is the parent who bears the cost. So in the school system
there is no support from any quarters.'
(Respondent 84.9, teacher/school counsellor, focus group
discussion, district level)

The teachers reported there were no special schools in the district. The nearest school for children with special needs is located at Nkoranza. Supporting children with special needs within the mainstream schools was said to be very difficult because of the large class sizes and low numbers of teachers which are typical of Ghanaian schools:

'Because of the large class sizes, it is always a very big problem…
They should have been handled and attended to individually, but
sometimes it is only few teachers who do that. For that reason we
do not have them given the necessary attention.'
(Respondent 61, manager, GES, district level)

Whilst there are no formal programmes for mental health education for students, one teacher reported that the social studies syllabus within the schools provides health education on some topics relevant to mental health such as teenage pregnancy, drug abuse and HIV/AIDS.

Training

Teachers reported receiving some training in child psychology within their basic teacher training. They did not mention receiving any post-basic specialist training. However one education manager stated that the education service provided training for teachers and parents in the causes of mental health problems:

'We try educating the teachers who are teaching them and this we
do it through workshops, seminars and we also move out to educate
the parents about some of the causes of mental health problems.'
(Respondent 61, manager, GES, district level)

Another manager mentioned that special education has been introduced within the curriculum of the teacher training colleges:

> '… special education has been introduced so that they will know the causes of mental retardation, causes of deafness, causes of blindness, and causes of maladjustment. All these social issues, social vices and social mischief, they are trained to know that at the training colleges'
> (Respondent 60, manager, GES, district level)

3.7.4.2 Police

A focus group was held with police officers from the district, as well as interviews with a senior police officer at the district management level.

Police officers defined the police role in mental health as responding to three situations: a government request to detain a person, the request of the family for assistance in dealing with a mentally ill relative, or when a person with suspected mental disorder commits an offence. They were clear that outside of these eventualities they did not intervene:

> 'You see that one we don't get the specific powers. At times, it comes from the government, government can give the order that lunatics should be kept indoors, or let's say they should be confined. Then we go and do. Or when a family member of such a sickler [person who is frequently sick] comes in to say that in fact the brother or his relative is suffering from that and he want us to help him arrest him, chain him, cool him down, bring him to normal, to be sent to any of the psychiatric hospital. Or when he commits an offence, then he will be arrested because the law has no respect that is what they say. So he will be arrested, and maybe when during his prosecution and it is learnt that his behaviour is not normal than they take him to hospital for examination. These are the three categories whereby police can come in. Apart from that when somebody is mad, he is mad. If he doesn't commit crime police we can't go in for the person unless government gives order or family

member brings him that he want to take him to asylum or psychiatric then we assist or he commit crime.'
(Respondent 87.2, police officer, focus group discussion, district level)

'The police, invariably we come into contact with mental patients or people who have got mental derangement, or at least they are not able to think the normal way we expect everybody to think. Occasionally, it is either the families of persons who have such people in their family request for the police assistance to send them to the mental hospitals because it is the request of the family before such persons will be sent to mental hospital. The police cannot wake up and arrest anybody and send anybody to any place. It is based on the request of the family who knows that that person is being deranged. Maybe he is very violent and they cannot control him, and they request for the assistance of the police and it is therefore their duty to ensure transportation from wherever it is to the mental hospital for the admission of that person for treatment. Then the second way one may come into police contact will be maybe through criminal offences, maybe the person might have committed a crime, that crime the police may not know that he is a mental patient but in the course of investigation you found that he is not normal. He is sent to court, the court will give an order that he should be sent to mental hospital for medical examination and report. Thereby the necessary treatment must... not just to be examined and report, but he has to be treated until he is to such a time that he is fit and qualify to stand trial, otherwise he will remain in the mental hospital there until such a time that he is declared mentally fit. These are the means that through which we come… normally such persons come to our domain.'
(Respondent 66, senior police officer, district level)

The police stated that they supported families to admit a relative to hospital where the family require additional help.

> *'…. if the family see that they alone cannot do it without the help of the police and they need police assistance, well, that one, police assist them to send the person to the hospital.'*
> *(Respondent 87.1, police officer, focus group discussion)*

This respondent stressed that the decision to someone who had committed a crime to the psychiatric hospital rested with the courts, and not the police service:

> *'Any instruction for somebody to be sent to the psychiatric hospital if he has committed offence is the court. I will not personally instruct that he should be sent to the mental hospital straight away. He has committed offence we put him before court….,.'*
> *(Respondent 66, senior police officer, district level)*

Police officers reported having very limited knowledge of current mental health legislation:

> *'A decree, you know we have not gone so much into it, but yes I know there is a bill. But what we know so much is when somebody is mentally challenged in law, we can't prosecute the person, so the appropriate thing to do is to advise the family to send the person to the appropriate quarters.'*
> *(Respondent 87.1, police officer, focus group discussion, district level)*

One senior police officer at the district level frankly reported having never seen the Mental Health Decree:

> *Interviewer: 'There is a decree in Ghana that deals with mental health cases, that is the 1972 Mental Health Decree. Are you aware of the provisions of that decree?'*
> *Respondent: 'I'm yet to see a copy of it. I haven't seen a copy of it.'*
> *(Respondent 66, senior police officer, district level)*

One officer reported that the law allowed them to handcuff those who were 'wild' when escorting them to hospital:

'When the person… you see that you can escort the person without handcuffing him you can do that, but if you notice that the person is so wild you can't escort him without handcuffing him, then that one, the law makes provisions that handling somebody you have to handcuff him.'
(Respondent 87.1, police officer, focus group discussion)

Police officers reported having no standard written guidelines on the management of people with mental disorders. They had received no training in mental health legislation, nor any training in identifying and handling those with mental health problems. Rather they seemed to draw on experience in identifying and managing those they suspected of having mental illness:

'….handling of mental patients and all these things is not our number one function, therefore you have just little knowledge about how… who is a mental patient, except that he comes and somebody identify him to you. The policeman cannot just on his own identify him except maybe those who had been in the system for a long period, that maybe knowing the mental psychology of human being, can know that this person is, physically or mentally or spiritually, is not sane.'
(Respondent 66, senior police officer, district level)

'….we have not been trained like to identify people like that, but when here… or when somebody commits an offence and we are going for the person during maybe his interrogation here you may get to know psychologically that the person is mentally ill or something like that.'
(Respondent 87.1, police officer, focus group discussion, district level)

'You see there are no actual guidelines, all is using your discretion.'
(Respondent 87.2, police officer, focus group discussion, district level)

The police officers interviewed stated there is no dedicated budget within the police service for mental health. There are no allocated funds for the police to send persons with mental illness for treatment. In this case the costs are met by the family:

> *Respondent: 'For example if it is the family who has approached the police, it is the duty and responsibility of the family to provide transportation. We are assisting, it is the responsibility of the parents or the families who have identified that person to be a patient. He is wild, he is not able to be controlled by them, therefore they seek police assistance. It is their responsibility to bear the cost of transportation of the policeman together with the person involved to the mental hospital and bring the policeman back to his base. So this…except where is a criminal case and the court has given order then it means the police is responsible for transporting that person to the mental hospital.'*
> *Interviewer: 'So in that case it will be just part of the police resources that are there, there is nothing put specifically for…?'*
> *Respondent: 'No, no, nothing is put in place that for mental patients or people who are mentally sick or affected should be used in handling them or anything, there is nothing like that, and I don't think I have heard of some in the system.'*
> *(Respondent 66, senior police officer, district level)*

Aside from the lack of funds, the distance of the psychiatric hospitals from the district means that it is very difficult for the police to help people with mental health problems to access treatment:

> *'...... if you are in the north or you are here and there is any such situation, you need to travel down south as you even mentioned earlier, and you know the cost of transportation and other things. Those things and the… for example if every region there were to be a psychiatric hospital, is easier. So such facilities actually don't exist, except you are very close to the south or where those things are. So it's difficult.'*
> *(Respondent 66, senior police officer,, district level)*

Police officers reported that the difficulties in arranging transfer to the psychiatric hospitals also lead to people with mental health problems being detained in the police cells. They were aware this impinged on the person's constitutional rights, but felt they had little alternative, given the risk that the person might offend if they discharged him back to the community:

> *Respondent: 'You know some time when somebody is disturbing in public, you have seen that he is mentally handicap, though the constitution provide for forty-eight hours for somebody to be in cells, but when you see that he is so furious and even the families agree that he is so furious, and maybe they are preparing to send the person to the psychiatric hospital, and maybe they are not having money at that short period, you can keep the person above that forty-eight hours. That one you are violating the person's right, yet there is no way out.'*
>
> *Interviewer: 'So assuming the person comes back normal and say that maybe you have kept him in prison for more than twenty-four hours. He is going to charge the police for that? What will you do?'*
>
> *Respondent: 'No, he can not, because it's the circumstance that brought that, its the circumstance, you are mentally… and when we leave you, when even you go, what about if he leaves here and he go and kill somebody in the family? If we are saying constitution allows for what and what, but you, your circumstance has make you….. that if we leave from here you could go and kill somebody. Should we allow that? We can't allow.'*
>
> *(Respondent 87.1, police officer, focus group discussion, district level)*

Police felt that a dedicated budget for mental health could help to improve the service for people with mental health problems:

> *'If we could have, have a budget for it, it could help us a lot because you know those people…it will help us by sending to the appropriate quarters for treatments, but because we don't have any budget for that, normally it becomes a burden. Even here when you keep such a person here you will have to feed the person with our own money'*

One police officer also suggested that training in mental health should be provided as part of the training for police officers in Ghana:

> *'…..if you want the police to play a major role then it means the authorities responsible for health need to arrange with the police authorities to incorporate these type of training into our syllabus so that in the training schools they are given information, they are given the necessary training as to how to maybe identify….. and what measures even when you identify: how are you going to handle that person? Because where are the resources? Where are the facilities? Where will you take the person when even you identify? So that I think, that should be taken up by the authorities'*
> *(Respondent 66, senior police officer, district level)*

3.7.4.3 Social welfare

Social Welfare was reported to cover three main areas: Justice and Administration, Child Protection and Community Based Rehabilitation (CBR). CBR included mental health within its remit. There are only two qualified social workers in the district. The budget for social welfare comes from the District Assembly. The social welfare department has a role in supporting those who are destitute, however one worker reported that they struggled to meet their remit due to the paucity of funds:

> *'But now we don't even have grants to the office, we don't even have money. Even this papers we using, at times we buy them ourselves. There is no money, so nothing is being done.'*
> *(Respondent 64, Social Welfare department, district level)*

Social workers estimated that between 10 and 15 cases per month presented with mental health problems, and comprised about 25% of the caseload for disability. Social workers reported a complex process in accessing care and financing for those who presented with mental illness which involved liaison with a number of agencies from the police to transport services:

'The roles and services is not easy. What we normally do is, first, when we see any of such people and they are aggressive, the first thing we do is we report to the police and we then leave with them, then we are able to administer the services. After that we report to the hospital for drugs. After that we have to…like I talk of the GPRTU [Ghana Private Road Transport Union], we have to contact them for vehicle, and then after that, that doesn't end, we have to contact the Assembly for financing because we will be ask to buy fuel whatever, whatever….. After that we have to contact the District Assembly if they will finance. After that the person is then sent to the psychiatric hospital. We trace for the parents if a child or the relatives if an adult.'
(Respondent 64, Social Welfare department, district level)

Patients who require inpatient care were reported to be usually sent to Ankaful Psychiatric Hospital. In the case of children being brought with mental health problems, social workers would ask the parents to assist with medical expenses:

'If the child is brought here first, the first thing to do is we take him to the hospital to find out whether there is something wrong with the mind. If we find out that there is something wrong with the mind, we then decide to see the parents because if the parent is there and he is a child we ask him to bear all the medical expenses. If we couldn't treat fine, then we know that we are taking the child to the psychiatric hospital out of the district.'
(Respondent 64, Social Welfare Department, district level)

Social workers in Kintampo reported that there was a procedure for back referral from the psychiatric hospital when the patient was discharged. Social workers at the psychiatric hospital would inform them of the discharge so that they could prepare the family for the person's return.

Social workers identified a lack of funding and transport, as well as poor intersectoral collaboration with the police for example, as constraining their ability to meet the needs of those with mental health problems:

'Okay here we put no…. because of financial constraints and lack of means of transport, and we also lack information flow from intersectoral partners. Because at times the police have to feed us with some information but they will not do it, and if you ask them, they will not be willing to give you. Then also for example, I put health education and the police. There should be effective collaboration between the parties. Provisions of means of transport and modern technology where we have to source information and adequate financing. So if we get all these it will go a long way to help.'
(Respondent 64, Social Welfare department, district level)

Social workers reported receiving training in identifying mental illness as part of their basic training. This respondent distinguished between 'psychosomatic' cases, and 'wild' cases, which required seeking additional help:

'We have our own schools that teach us how to handle clients of different kinds. Because we have those that have mental health problems, those who find difficulty in movement, difficulty in seeing, and people have difficulty in maintenance and other things. So when you are in training that is where they will show you the kind of mental sickness. This man if psychosomatic patient you know he is not all that wild so you know how to handle him. But when you get the wild ones you know the steps to take. So that is the training they give to us.'
(Respondent 64, social welfare, district level)

However social workers had very limited knowledge of mental health legislation and had received no training in this area.

3.7.4.4 Housing

There is no government provision for specialist housing for people with mental health in Kintampo district.

3.7.4.5 NGOS

There are no mental health NGOs operating in Kintampo North and South districts.

3.7.4.6 Traditional and faith healers

There are many traditional and faith healers in Kintampo North and South Districts. Among those who provide treatment for mental illness are *akômƒoô* (fetish priests or traditional healers), who are practitioners of the indigenous religion, and prophets or pastors of the Pentecostal or Charismatic churches (here described as faith healers). Some of these are known for their success in treating mental illness and have compounds in which individuals and their relatives may stay for several months. Interviews were conducted with two traditional healers, one Muslim healer, and two pastors who treat mental illness. In addition a focus group was held with traditional healers.

Causes of mental illness

Many of the traditional healers saw the main cause of mental illness as being a result of a sin or a crime. In such cases confession was necessary for healing to take place:

> *'At times, it could happen that somebody might have gone in for another person's wife and then he will be struck by a juju, or somebody might steal another person's belonging, or it could happen that, as a result of some litigation, somebody may go mad. In all these, the person will have to tell what really happened before we would be able to find the medicine for the cure.'*
> *(Respondent 86.1, traditional healer, focus group discussion, district level)*

Faith healers also described spiritual causes for mental health problems, though they also stated that some physical conditions such as convulsion, severe malaria and brain damage can cause mental illness. They identified the use of drugs and alcohol as another cause of madness:

> *'The smoking of 'wee', these days is also a factor. It is the most common cause. After smoking the 'wee', they drink* akpeteshie *in addition, why wouldn't they go crazy?'*

Another possible cause was related to difficulties with emigrating:

> *Respondent: 'Sometimes too some complain about loss of job, or especially, those who are bent on travelling abroad come here with difficulty of getting genuine papers. This can even make them mad.'*
> *Interviewer: 'Does it mean it is as a result of thinking too much about the debt they may have incurred?'*
> *Respondent: 'Yes. They think about it. There is also a situation whereby the person might have been repatriated back to Ghana. The person can go crazy by thinking too much about it.'*
> *(Respondent 70, pastor, healing church, district level)*

Initiation and Training

Traditional healers usually receive their training through helping a parent, an uncle or a grandparent, or sometimes a non-relative, to harvest, prepare and administer medicinal herbs. In addition to this traditional healers undergo an initiation ceremony with their mentor who gives them the mandate to practice after their death. Such a person would continue to work under tutelage, and only assume independence after the death of the mentor.

Most of the faith healers said they were inspired by 'the spirit' or received a 'calling' to take up healing. Some reported that they became healers when they themselves fell ill, and after being healed through a church or a particular pastor, they decided to take up healing and help those in similar situations. These healers often trained under the pastors who treated them. This pastor described his initiation thus:

> *'I was a Methodist by denomination and I became sick. So I was roaming from one place to the other for healing up to the north. I went to a lot of spiritual churches seeking for healing. So when I heard about this church too I went there and the pastor prophesized that one day I will become a pastor. Before I went to this church, I went to one fetish priest at xxx. When he carried his gods he said 'A*

> *man of God is here', and he mentioned my local name and told me*
> *that one day I will be a man of God.....'*
> *(Respondent 73, pastor, healing church)*

None of the healers interviewed specialised in mental health problems; they all treated mental disorders as part of their general healing practices.

Traditional and faith healers had no knowledge about the existence and provisions of mental health legislation and policy.

There is a traditional healers' association in Kintampo, although not all healers are members.

Diagnosis of Mental Illness

The diagnosis and treatment strategies differed considerably among healers. Traditional healers would pour libation to invoke the spirit of God and that of their deity of worship to guide them in the diagnosis and healing process. Many healers use observation to determine whether the person is suffering from mental illness, and they look out for dramatic symptoms of mental disorder such as hallucinations, delusions and extreme agitation as signs of the illness. Invariably, the healer would ask the patients to tell their story if they are able, as well as eliciting the history of the problem from the caregiver who usually accompanies the patient. The need for diagnosis is important, especially for those who administer herbs, so they can decide which herbs to use in treatment.

One of the traditional healers uses a unique method of diagnosing mental illness by administering a herbal concoction to the patient on the first day of admission. If it is mental illness, the patient is sedated for three days and that enables the healer to make a definite diagnosis of mental illness. He is then confident to administer the herbal treatment.

Faith healers would start with a prayer, and then listen to the history of the patient's problem, either from the patient or their carer, before commencing healing activities such as prayer and fasting.

Treatment Strategies

Traditional healers predominantly treat with herbs, usually introducing some unique strategies to distinguish their treatment. One traditional healer for example treats patients with two different groups of herbs, depending on whether the patient is 'quiet' or 'aggressive':

> 'My grandfather taught me that when somebody comes with mental illness and he looks too quiet, there is a particular root that we go to dig and cut it into pieces, boil it, administer as nasal drop and give him some to drink. Some too come here very aggressive, they too there are roots that we go for and administer it to him and he will sleep for a long time and the aggressiveness will be cleared from his face and before he wakes up he will be very calm.'
> (Respondent 75, traditional healer, district level)

While some of the traditional healers stated that they learnt about the herbal preparations during their apprenticeship, some of them indicated that they need to consult the gods in respect of every patient that comes for treatment in order to receive spiritual guidance for the correct treatment:

> 'Yes, we find out from the god and he in turn reveals to us which medicine to use in curing a particular problem. The diseases are different so it is the god who reveals to us which medicine to use at every instance.'
> (Respondent 72, traditional healer, district level)

> 'The spirit can show how the person got the disease and also direct the type of medicine to be used to cure the disease. Every deity has its medicine that it uses to cure a particular disease. Apart from this medicine that is being used to treat this disease, the deity can show another medicine when a new disease is brought. The treatment depends on how you got the disease because we are guided by it to treat the disease.'
> (Respondent 86.5, traditional healer, focus group discussion, district level)

Many of the Christian faith healers exclusively used prayers and fasting for healing. The type of fasting prescribed depended on the severity of the condition and the modus operandi of the healer. Some involved moderate fasting, which allowed users to break their fasts after midday. This type also allowed the patients to drink water during fasting. At other times the patient may be prescribed "dry fasting", which excludes the drinking of water during the fasting which often lasts from 6 am to 6 pm. The period of dry fasting could be for a few days, a week, or for 21 days.

Fasting is normally done by the patient, or by both the patient and the caregiver. It can also be done vicariously by the caregiver alone, if the patient is not able to do the fasting. During these fasting periods, prayers are very intensive and emotional as the fasting periods are believed to be the peak periods for healing. Some of the Christian faith healers use items such as anointing oils and holy water to support the healing processes. Some healers also use herbs in combination with some of the above.

Confessions of wrongdoing, whether recently or in the past, is a key ingredient in healing for both traditional and faith healers. Some healers insist on confessions as the first step, before they start the treatment:

> *'It happens that, someone may be a witch or has done something*
> *wrong and as a result, has this problem. In that case, it is necessary*
> *for the person to tell the truth, before the right medicine to be given*
> *will be known.'*
> *(Respondent 86.5, traditional healer, focus group discussion, district*
> *level)*

Offerings of money and other items such as schnapps, and pledges made by patients to donate in cash or kind, are also believed to facilitate the healing process.

Referrals

Interviews with traditional and faith healers revealed that traditional and faith healers rarely refer patients to the orthodox practitioners. They gave three main reasons for this. The first reason is that they consider the underlying cause of mental disorders to be spiritual. There was therefore no need to refer for orthodox treatment because the conditions are not medical conditions and will not respond to allopathic treatment. Another reason for non-referral to the hospitals was that in some cases the patient

had already visited the hospital before coming to the shrine or prayer centre and had not responded to orthodox treatment. This confirmed the spiritual nature of the disorder and the need for spiritual treatment. The third reason given for non-referrals to orthodox medical practitioners was to do with solidarity among traditional healers, who would prefer to refer to another healer than to a doctor:

> *'We the fetish priests, we are one, like the doctors, and so when*
> *someone comes to me and I am unable to treat him/her, I can direct*
> *the patient to another fetish.'*
> *(Respondent 86.2, traditional healer, focus group, district level)*

Many of the traditional healers said they would normally refer a patient to another healer when they found the condition very difficult to manage. Some said they would refer the person to a more powerful healer to take over the treatment process. Some said they would continue to treat the patient but would work alongside another healer who had more authority in an aspect of the patient's problem. Others said they would combine spiritual forces with another healer for the management of some patients especially in more complex cases. Some also stated that a deity may inform the healer to refer the patient specifically to another deity because that deity has the cure for that particular disorder. This may occur when the healer is in trance:

> *'In the same way a doctor gives a referral note to a patient to take*
> *it to Techiman or Jema hospital, so can the deities also direct*
> *somebody to go to some places. For instance, it may say… if you*
> *take your illness to 'Akwatia Firi', it will tell you that, for that*
> *particular disease it does not have a cure and so take it to 'Kyiri*
> *Akyingye'''.*
> *(Respondent 86.5, traditional healer, focus group, district level)*

Some healers indicated that there were rituals that were performed to inquire from the deity whether they can cure the disorder or not, and the response should be affirmative before they start the healing process. One such means of identifying whether the healer can cure a particular disorder is through slaughtering a chicken. The posture in which it dies indicates whether the healer is able to cure the disorder. If the healer is not able to cure the patient he may refer the patient elsewhere. There is a tendency for healers to consider that if a patient is not responding to treatment

the fault lies either with the patient or the healer, and the healer will attempt to correct this rather than refer elsewhere.

Some faith healers and traditional healers said they sometimes advised patients to use orthodox medical treatment alongside spiritual treatment. One of the faith healers stated that he normally refers patients to the hospital to rule out physical conditions before he starts the healing process, and would encourage them to continue with their orthodox medication while he deals with the spiritual realm:

> *'Mental illness is spiritual illness. When somebody comes to me I first of all let him go to the hospital for treatment and when he comes back from the hospital I put him on fasting and prayers. We fast and pray for him till he gets well.'*
> *(Respondent 73, pastor, healing church)*

A traditional healer stated that he would prescribe his treatment first, and then add the doctor's medication:

> *'When someone comes, the medicine that I first of all give to make the person sleep is not taken together with a doctor's prescription. After going through my initial medication, you can then add the doctor's prescription.'*
> *(Respondent 71, traditional healer)*

Traditional healers explained that whether a person could use traditional and biomedical treatment at the same time depended on the type of medication prescribed by the doctor:

> *Interviewer: 'Is there anybody who is on medication by the doctor and comes here for traditional medication and taking both medications at the same time?'*
> *Respondent 86.7: 'Yes. We do allow them to take the medication at the same time.'*
> *Interviewer: 'Does this cause any problems?'*
> *Respondent 86.1: 'It depends on the medicine that the doctor might have given to the patient. It could be a blood tonic or malaria drug. If you combine these drugs with that of traditional medication, there is*

that of traditional medication, there is no problem. If it is any other medication, then I will tell you to complete the doctors' medication before taking the traditional medication.'

Interviewer: 'Does it mean that, you believe that the orthodox medication and traditional medicine can work together?'

Respondent 86.6: 'Yes, it can. Formerly, doctors did not accept traditional medicine, but now, they have realized that traditional medicine can cure diseases. So we think that, the two can work together.'

(Traditional healers, focus group discussion, district level)

However one healer stated that since 'white man's medicine' and African medicine are completely different, they cannot be used simultaneously:

'I don't allow them to use the two medications at the same time. When I give them medicine, I tell them to use mine alone at any point in time, and not to mix it with what the doctor gives them. The power in the Whiteman's medicine and the one in ours is totally different. So if you use mine and see no improvement, then you can go ahead and use the orthodox medicine.'

(Respondent 72, traditional healer)

Some religious healers expressed a willingness to collaborate with orthodox medical practitioners in meeting the spiritual and physical needs of patients:

'We do spiritual work and the doctors do the physical work…..When someone comes here and the sickness is serious we refer him to the hospital. So when we are working on the spiritual aspect, the doctor will also be working on the physical. If the doctor fails then it is left with God.'

(Respondent 73, pastor, healing church, district level)

'Those illness I try all possible means yet is not going, I advise them to go to the hospital so that the doctor can diagnose what is wrong with them. Because the medicines are the same so if someone comes here and is above my control I refer him to the hospital.'

(Respondent 75, Muslim healer, district level)

3.7.7 Summary

There are very limited resources for meeting the needs of those with mental health problems in Kintampo North district aside from the district hospital. There is no dedicated budget for mental health and no mental health professionals in the district. Mental health was perceived to be neglected in health services in the district and there was very little data available on the extent of mental disorders. Health workers at the district level had virtually no knowledge of mental health policy and legislation, no specialist training in mental health, and no support from the regional or national level in supporting those with mental health problems. Nonetheless they attempted to manage the cases which came to health services using the limited resources available such as sedative medication, and referring to specialist services at the regional or national level. However they sometimes had problems with the supply of psychotropic medication and had no resources to assist families in escorting their relative to hospital. There was also limited communication with the psychiatric services which means that there is no effective follow-up for patients once they are discharged. There is no programme for mental health promotion in the district. Low levels of literacy, particularly among women, and the mixture of ethnicities and languages in the district means that some are excluded from access to information within health services.

Health workers suggested that an outreach service from the psychiatric unit at the regional hospital could assist in developing the district capacity to work with those with mental health problems. Health professionals also expressed the desire for a CPN to be established in the district, or even an inpatient facility within the district hospital.

Explanations for mental health problems at the district level were similar to those elicited at the national level. They included physical, spiritual and psychosocial causes such as poverty, unemployment, stress and frustration, and the use of drugs and alcohol. 'Spiritual' causes such as curses or witchcraft, were also seen as significant. Participants also highlighted perceived gender differences in the experience of mental illness, with women seen as vulnerable to stress and depression due to the inferior position of women in society, the burden of childcare, and marital problems. Men were seen as more susceptible to peer pressure, and prone to madness or psychosis, both often linked to cannabis and other drug use.

Respondents saw an evident link between mental illness and poverty in the district. Poverty was seen to result in deprivation of the barest necessities of life, and thus to worrying or thinking too much which could in turn lead to madness. Participants expressed a need to address the root causes of poverty in order to reduce the impact on mental health. There was also an identified need for schemes to provide vocational rehabilitation and income generation. The mentally ill are reported to be heavily stigmatized in Kintampo district. They are seen to be violent and unpredictable and are often excluded from work, marriage and family life. Participants suggested the need for education and sensitization in order to tackle stigma in the district and enhance knowledge of mental health.

Interviews with participants from Ghana Education Service, the police and social welfare revealed a similar lack of resources for mental health within those services. In the education service, whilst national policy has introduced initiatives such as school counselors, these were seen to be of poor quality in practice. Teachers reported some training in psychology during their teacher training. They addressed the needs of students with mental health or learning difficulties through engaging the family, referring to the school counselor and if necessary, to the district health services. They reported difficulties in meeting the needs of students with special needs, due to large class sizes and virtually no specialist support.

Police similarly reported restricted resources in dealing with those with mental health problems. They were clear about their role and its limitations in supporting families in dealing with a disturbed relative or dealing with criminal cases, however they had no training in mental health, and no guidelines in how to identify and manage those with mental disorders. They had virtually no knowledge of current mental health law and no dedicated budget for mental health. The practical difficulties in escorting patients the long distance to the psychiatric hospital means that there is often a delay in sending them. Police and teachers stated that in the absence of resources for transportation, family members are most often left to escort their relative to hospital.

Social workers treat those with mental illness as indigents or disabled. They also reported a paucity of funds to address the needs of those with mental illness. They described poor intersectoral collaboration, for example in sending a patient to the psychiatric hospital.

Traditional and faith healers in Kintampo were familiar with mental illness or madness which they described as the consequence of some immoral behaviour, or as a result of physical causes such as malaria, and the use of drugs and alcohol. The main forms of treatment for mental illness involve the use of herbs, ritual confession, and prayers and fasting. Healers receive training from other healers and pastors who serve as mentors, and rarely co-operate with health services in the treatment of mental illness. However some healers expressed a willingness to work in collaboration with biomedical treatment for mental disorder, with orthodox services addressing the physical problems, and traditional and faith healers treating the spiritual causes.

3.8 Service Users

Unfortunately due to time constraints, no service users were interviewed at the district level in Kintampo North and South district. However data on the experiences of people living with mental illness in the districts is available from an anthropological study which is in progress. This includes interviews with people with mental illness and family members. Data from a preliminary study is available which reveals a significant impact of mental illness on family life, financial circumstances, employment, marriage and child-bearing. Multiple help-seeking from traditional healers, churches as well as biomedical facilities is common (Read 2006).

In 2007 a study was conducted with outpatients at Accra Psychiatric Hospital on the effects of living with chronic mental illness (Department of Psychiatry, University of Ghana Medical School 2007). The study compared the experiences of patients living with chronic mental illness to those of patients living with chronic physical illness. Patients were interviewed by medical students as part of their project work in psychiatry under the supervision of two psychologists, Drs Ofori-Atta and De-Graft Aikins, and the results presented at the Psychiatry Department's annual student conference.

Out-patients diagnosed with schizophrenia, affective disorder, and epilepsy were compared with out-patients living with diabetes and hypertension. The method was semi-structured interview focusing on the effect of the disorder on the individual's quality of life, his/her family, work and community relations. There were 10 patients for each diagnosis of mental illness, and 20 in each of the two groups with physical illness giving a total sample size of 70. There were 44 women and 36 men. The three groups living with mental illness were comparable in age, level of education, and employment.

Table 9: Costs of Living with Illness

	Affective Disorder	Schizo-phrenia	Epilepsy	Diabetes	Hyper-tension
Average number of hospital visits per year	11	9	9	6	10
Average time spent per visit	2 hrs	4 hrs	3 hrs	5hrs	3 hrs
% admitted since illness started	40	100	40	25	10
Average number of admissions since illness started	3	3	9	1	2
Average duration of each admission	4wks	3months	17 days	10 days	5 wks
Expenses on medication per year (GHC) (mode) and range	55 5 – 300	20 3 - 300	20 3 – 300	200 80 - 960	 10 - 120

No formal statistical analysis was conducted to compare the differences between the groups because of the small sample size. Patients visited the hospital almost once a month, except for those with epilepsy who visited 6 times a year on average. A greater percentage of those with mental illness had been admitted since the start of their illness than those with physical illness. Among these, all those with schizophrenia had been admitted at least once. The average number of admissions since the start of the illness was highest among those with epilepsy and least for those with diabetes. Duration of admissions was noticeably less for epilepsy and diabetes. The cost of medication for diabetes was the most expensive, followed by hypertension. Affective disorder, schizophrenia and epilepsy were less expensive due to the free treatment of mental illness in government hospitals.

The experiences of more than half of those living with mental illness included poor self image as a result of stigmatization, poor social relationships leading to isolation, and lack of order in their life. They felt a financial burden from illness and all had been affected in terms of employment. 70% of those with schizophrenia were in blue collar jobs, mostly petty trading, and unable to work all the time because of drowsiness from medication and symptoms of illness. They also experienced stigma.

They reported being mocked and looked at strangely. Among those with affective disorders, relationships had been adversely affected with two divorces among the group, and a report of disinterest in sex. They were accused of being lazy (in depression) or of witchcraft (in mania). Epileptics reported learning problems in school, and being mocked, insulted and ill-treated within their communities.

People with diabetes and hypertension tended to be older and were supporting others financially. In general, for most of them, job performance had not been affected and there was no stigma associated with the disease. For those with hypertension, physical constraints such as fatigue were reported by 50%.

Chronic mental illness significantly affected the education of patients as the illnesses started early in life, and lasted until adulthood. Patients with chronic mental illness also tended to be dependent on others. The study concluded that much stigma was associated with mental illnesses because these illness were viewed as mysterious and attributed to spiritual causes.

A follow-up study in 2008 (Department of Psychiatry, University of Ghana Medical School, 2008), also conducted by final year medical students supervised by the same two psychologists, confirmed these findings. In this second study patients living with mental illness reported feeling stigmatized and also said that their family members were stigmatized for having a relative with mental illness, with even their children suffering verbal abuse within the community. This study concluded that it was more difficult to live with mental illness than with physical illness.

3.9 Key Issues in Mental Health Service Implementation in Ghana

Respondents were almost unanimous in arguing for a move away from institutional care in the psychiatric hospitals, towards the provision of mental health services at the community level, alongside primary care.

3.9.1 Integration with primary care

It was clear from both the WHO-AIMS and from the interviews that despite some attempts to integrate mental health into primary health care delivery, the majority of mental health care in Ghana remains concentrated in the psychiatric hospitals:

> *'…I am not sure how successful we have been in terms of trying to make mental health care delivery as part of the normal health delivery system. Because that is also one of the issues that need to be addressed…… But the whole concept of having mental diseases totally off the general hospital campus is in itself….. I mean in the past look at where our mental hospitals have being sited. Our mental hospitals are sited on the outskirts of town. I mean it gives the impression, you know, you must be out there. Well now Accra has grown, so Accra psychiatric hospital is in the heart of the city, but the issue is that this used to be on the outskirt of Accra. Pantang is the same, Ankaful is the same, I mean, so that has been the practice.'*
> *(Respondent 5, senior academic health researcher)*

Several respondents suggested the integration of mental health into existing public health initiatives in order to raise awareness at the community level. It was reported that there had been efforts made to train non-mental health workers such as Community Based Surveillance volunteers, and community-based surveillance officers in mental health in order for them to be able to identify cases in the rural areas and refer them for treatment. In 1999 the World Health Organization piloted a scheme through the 'Nations for Mental Health' initiative to train volunteers to recognize signs and symptoms of mental illness and refer cases to the CPNs and

other mental health care providers. The scheme was piloted first in the Eastern region, and then extended to the Ashanti, Central and Greater Accra regions. The volunteers also provided follow-up for cases in the community to monitor relapse. Primary health care providers including medical assistants, doctors, public health nurses and midwives, were trained in the management of psychiatric disorders (Asare 2003;WHO 2002). Whilst this project had some success in increasing the detection and treatment of mental disorders in the communities where it was implemented, the expected expansion of the scheme to other districts did not take place due to lack of funding.

One respondent suggested the use of CHPS volunteers to work in mental health:

> *'We are talking of CHPS and so CHPS, these people are trained to be CHOs* [Community Health Officers]. *So what do they do? They stay in the community to provide health service at the doorstep of the rural folks and so if this person is trained in mental health nursing, then that person will be there to address that problem there.'*
> *(Respondent 31, senior academic psychologist)*

Another respondent suggested that public education campaigns on mental health could draw on lessons from campaigns on increasing community awareness and detection of HIV and AIDS:

> *'There must be a constant education like how they are hammering on AIDS, the same thing too must be applied to mental illness, the causes. And then people must be well educated: "If you see a person behaving this way, report so, so and so, let or send the person to the hospital". …'*
> *(Respondent 21, programme director, MOH)*

Respondents recommended that effective treatment of mental disorders must be within the capacity of every doctor within district health services, rather than concentrated in the few specialists at the psychiatric hospitals:

> *'…. and at least every doctor must be able to help. It isn't necessary sending the person to the psychiatric hospital. If they are few as we*

are saying, and someone is in Tamale and is involved in that sort of thing and there is no vehicle or the parents cannot afford to send the person down to Accra to come and live here and get bored etcetera, then the person will be lost in society so every doctor must be of help. Every single doctor must be able to help a mentally affected person to come out of the situation immediately. It is not the matter of sending the person to the psychiatric hospital.'
(Respondent 21, programme director, MOH)

Aside from increasing ease of access to treatment, the development of mental health within primary care would also remove some of the attendant stigma by preventing the need for patients to attend the psychiatric hospitals:

'…the moment you send somebody to the psychiatric hospital and people see it that is the end. The person is stigmatized. That is what people say, he has been there before, and that can even worsen the case of the person. So my suggestion is that every doctor who is in the clinic or whatever can first, or let's say give first aid to suspected people who are about to have mental illness…..
(Respondent 24, Ministry of Information)

3.9.2 De-centralisation and the need for community-based mental health services

The need for a move away from institutionalised mental health care and the development of community-based mental health services was widely recognised among participants. Previous attempts to develop decentralised systems of mental health care delivery have been implemented with additional funding from external donors (as with Nations for Mental Health described above). These have shown some measure of success, but unfortunately were not sustained once external funding ceased, nor rolled out comprehensively to the whole country.

One of these initiatives took place between 1996 and 1999 as part of a Health Sector Support Programme (HSSP) funded by the Danish Development Agency (DANIDA). A programme was developed to integrate mental health services into primary health

care in the Upper West Region of Ghana. The first part of the programme included the development of manuals (Ofori-Atta & Sefa-Dedeh 1996;Ofori-Atta & Sefa-Dedeh 1997;Ofori-Atta, Sefa-Dedeh, & Ohene 1996;Ofori-Atta, Sefa-Dedeh, & Ohene 1997) to train all senior and middle level health administrators in the region, as well as primary health care givers, such as doctors, nurses and psychiatric nurses. Following this there were workshops to introduce the concepts of community-based care, as well as the opening of a psychiatric wing in the regional hospital. Community psychiatric nurses (CPNs) were employed in each district who received quarterly supervisory visits from a psychiatrist and two clinical psychologists from Accra. The final part of the programme included visits by the doctors, nurses and CPNs for further training and familiarization with psychiatry at Accra Psychiatric Hospital. The programme lasted four years. During this time the visits of CPNs into the communities ensured that many patients who had been chained to trees and walls were released as they were given medication which reduced agitation. However, epilepsy in both children and adults made up the highest proportion of cases treated by CPNs.

After the programme ended over the years many of those trained were gradually transferred to other parts of the country. For instance, the psychiatrist in charge of Ankaful was the general doctor in charge of Tumu district at the time and he had participated in the programme. However the regional hospital continues to be one of those in the country with a psychiatric unit, and the concept of community psychiatric nursing is well established. The project also generated research into the use of alcohol in the region (Ofori-Atta et al. 2006), and patient-staff interaction as a measure of quality of care (Sefa-Dedeh et al. 2006).

Integrated primary and mental health care is thus a model which has been shown to operate well in different parts of the country at different times. However it has not always been sustained for long periods of time partly because of insufficient funding, but also, as in the case of the HSSP, the lack of commitment to such a model of integration by the MOH. In this case, there was dedicated funding by DANIDA during the life of the project. However, after three years, the funds were placed in the common fund and MOH was expected to determine how this budgetary support was to be spent according to its priorities. This model was allowed to continue but without the regular supervision of the consultants who had set it up and who had maintained the services and no replacements for these consultants were found to continue to provide support. Services in the Upper West Region then reverted to what pertains to

CPNs in the rest of country, that is no ongoing training and support provided by psychiatrists and psychologists .

Because of the demonstrated success of integrated primary and mental health care both globally and in such schemes within Ghana, some policy makers and psychiatric professionals expressed their conviction that community-based health care would facilitate the integration of those with mental illness into the community:

> *'….we are saying that in this part of the world, well, we don't have… our health institutions are not that advanced, and things. Keeping people in institutions would only put more pressure on as it is, so whilst we can use the community system why don't we use that? Integrate them into society and then even support them because people are mentally ill really cannot work and then they are thrown out of jobs, and that really worsen it. So the community mental health issue would look not only on their health, but even support them their well-being, their welfare, and that kind of thing and I think it is catching on.'*
> *(Respondent 16, World Health Organization)*

> *'…..what is actually the top priority is actually about decentralization and focusing on community mental health, we want to actually look at mental health, not only in what I will call isolated institutions, we want to enter into the community and then what I will call de-boardinize the patients from the psychiatric hospitals, settle them in their communities so that we can actually build the capacity of the carers to take care of them in the community'*
> *(Respondent 10, programme director, MOH)*

This respondent talked about the need to 'take psychiatry to the people' through developing community-based services, rather than waiting for patients and their families to approach the psychiatric hospitals:

> *'Now the idea of taking psychiatry to the people in the village to my mind is the most important thing, because if you wait for them to come to the clinic for health they won't come because reaching*

psychiatric hospital or mental hospital, Ankaful or Pantang or Accra they won't come because they think they are not sick. But if we take the psychiatry to them in the villages there are more places and explain to them some of the causes, some of the contributory factor to mental illness I think it will be a very good policy in the mental health that we comes to what we call the community psychiatry, in fact that is what I am talking about, should be improved. Community psychiatry should be improved so that we take psychiatry to the people in the villages and not wait for them to come to hospital.'
(Respondent 56, psychiatrist)

The development of community-based services it was suggested, might help to relieve the pressure on the psychiatric hospitals by treating less severe mental illnesses in the community:

'….we don't have enough counselling and treatment centres in the country. I say so because most of the cases that come to the hospital are not supposed to come if we have these centres around if we talk out of stress for instance to me, this should not be a problem that should be brought to the psychiatric hospitals there is to me a minor case that can be handled at these centres if they are there.'
(Respondent 22, accountant, psychiatric hospital)

Whilst there have been some efforts to de-centralise mental health into the regions, this was reported not to have been uniformly achieved across the country:

'We have over the years tried to decentralize mental health which to some extent was successful in doing so. But the recognition of mental health in the various regions are not uniform, they are not uniform, they don't accord them uniform status. You will find some regions where mental health is well embraced and our staffs there are integrated into the primary health care system, and you find places where mental health is not given the desired attention and leading to frustration among the personnel in those regions and districts'

Respondents noted the unequal distribution of mental health services between the north and south of the country. The absence of mental health facilities and professionals in the north makes it very difficult for those outside of the southern part of Ghana to access specialized mental health care. This respondent in Kintampo, the demonstration district where at the time of research there was no CPN in post, argued for greater equity in the distribution of mental health services:

> *'Where are the mental health facilities in this country? They are all based in the south; Pantang hospital, Ankaful and then Accra, three okay? The whole of central Ghana, the whole of northern Ghana there is no facility. So when people are sick you need to…you can imagine, get them bundled, and then send them all the way down to one of these facilities at the coast. They get there and they don't have families to support and life is… Why can't we decide as a country that in each of the ecological zones, the northern belt, the middle belt, the southern belt at least, such facilities are sited? In this district, Kintampo district that we work, not even a nurse, a psychiatric nurse to care for any cases that come. So this clearly is telling you that there is lots of negligence against the mental cases'*
> *(Respondent 18, senior health researcher)*

Those community psychiatric services that exist are not efficiently run due to lack of qualified health professionals and material resources, such as the supply of medication and availability of transport.

It was also observed that there was a lack of mental health facilities outside the hospitals, such as 'half-way homes' and day centres, to provide rehabilitation for psychiatric patients to facilitate their return to the community and prevent relapse. Indeed there is little rehabilitation for inpatients in the psychiatric hospitals to prepare them for returning home:

> *'Can you imagine? They just open the gates, psychiatrists, open the gate, and say: "You are free to go". I don't think that is good enough, it is not good enough, they don't even have money to take transport to wherever he is living. You don't expect the person to walk to*

Nsawam. So certain prelims should take place, that is pre-discharge activities should take place. Is it going to be in the form of financial support or whatever? Find out what the person is interested in doing after leaving the premises. All that he probably has known for the past years is four walls, that the meals are regular. Now you leave out of the gate he doesn't even know, is not sure of his next meals,. What do you expect him to do? ……. because these people are coming out to live with us in the communities and if you don't treat them right what is going to happen? They would definitely have relapse, they would be sent back to institutions, government would pay more money for their upkeep when we could help to rehabilitate them and let them live decent lives'
(Respondent 19, Department of Social Welfare)

Several respondents suggested that more regional centres for mental health care should be established, particularly in the north of the country:

'I'm suggesting that they open branch at every region, these psychiatric… if not a full a branch, a sub-station, because some of their family members, they want their family to be treated but at times, the whole house…. who is to bear the responsibility? And even the transport from here to…. maybe as you saying Ankaful, even they can't afford..'
(Respondent 87.2, police officer, focus group discussion, district level)

One respondent suggested that mental health units should be established within each regional health administration to oversee mental health in the districts.

One social worker cautioned that some families may be unwilling to receive back their relatives with mental illness due to stigma and suggested that this should be considered in developing community services. He suggested a 'half-way home', where people could receive vocational rehabilitation in order to be able to support themselves in the community and reduce social exclusion:

'They give wrong addresses most of the times and even where the addresses are accurate, you go there people are still very

resistant, they are not willing to receive them back and that is very difficult to convince people that: "Give this person a break. The person has been to hospital, this person is treated and is for you to further help with the rehabilitation process, we are doing our bit but the work is left to you because the person is come back to you to live with you in the community and the person must be treated with respect and love and affection let the person feel welcome back home, but the moment you start resisting, the moment you start putting in rules again, they are going to have a relapse". And unfortunately many at times it happens they go there they are not welcome, nobody cares about their meals. I wish maybe that is something we should be working on, both Ministry of Health and probably with this other ministry, talking about the half-way home, half-way home, when people are about to leave they can probably go there and probably even learn a trade, a trade that they can go when they finally leave the scene they can make money and live independent lives, because when they go back they have nothing to fall on, and you know the economic situation, people are probably not just even willing, they said: "Everyone for himself, God for us all".
(Respondent 19, Department of Social Welfare)

3.9.3 Human resources for mental health

Many respondents discussed the very low level of human resources in mental health, from psychiatrists to nurses and other health professionals. Many psychiatrists, nurses and CPNs working in mental health services in Ghana are nearing retirement, and there are no qualified staff to replace them. In part the low level of psychiatric professionals was attributed to the 'brain drain' which was perceived to have particularly affected mental health, as well as staff attrition from mental health to general health care:

'In terms of service delivery I will say psychiatric is lacking behind because most of our trained staff I think when you…is abroad they are paying more than what we are receiving here so most of our staff the brain drain is hitting us here I think even more than the

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general side, and I think this one the human resources or the government should take this thing up, because it seems if you go to the ward and you count the number of nurses and the number of patients the nurses are attending to it is woefully inadequate…..The skeletal staff itself - if we are supposed to have 10 nurses on the ward, you see, if we have 3 nurses and that is skeletal already. So where do we go? The skeletal is nothing. That means as for us if they are doing anything we don't enjoy because the nurses are limited, and then we have to kill ourselves to do a lot of work. Sometimes you have to forfeit your "off" because the nurses are not sufficient, you have to stay in to help the patients.'
(Respondent 35.3, psychiatric nurse, psychiatric hospital)

The shortage of professionals within mental health services was seen to have serious consequences for the quality of patient care:

'In the community and the institutions themselves, let me tell you, if you are caring for the mental patient, you must observe the behaviour of the patient, you must talk to the patient, talk to relatives, to be able to tap proper information to help you write best reports about the patient to the psychiatrist, to be able to know what type of treatment to be giving so the patient can recover early. Imagine a ward with about one hundred and sixty patients with about four nurses, two nurses caring for such huge number of patients. What type of observation can you make? How many patients can you properly observe and write proper report about these patients so that it will help the psychiatrist or doctor to be able to determine what to do for this patient?'
(Respondent 8, mental health NGO)

The shortage of mental health staff is particularly acute within community psychiatric services, with no community-based psychiatrists and very few CPNs. This means that mental health care is largely curative rather than rehabilitative or preventative:

'…the problem is that there are very few community psychiatric nurses, very, very few in the system. I know that with one areas their preventive aspect of mental health is the work of the community

psychiatric nurses, apart from seeing to rehabilitation after treatment, but they are in the community and they should be talking about educating people about drug abuse, and listing of stress and things like that, but they're so few in the system.'
(Respondent 51, senior nurse educator, regional level)

Only a handful of clinical psychologists, social workers and occupational therapists and assistants are working in the mental health system. Given the limited numbers of personnel, the ability to provide holistic care including psychosocial interventions and rehabilitation is very limited:

'You see in psychiatry, psychiatry is a holistic thing from the physical illness to the social aspect of it that is why our ancestors left us in tight link with occupational therapy, in tight link with rehabilitation, in tight link with social welfare department, all our institution have the social welfare department functioning in them, the interlinkage is so important but it is not functioning. Our own occupational therapy departments are functioning at very small percentage. Our social welfare departments have been reduced to repatriating departments. Their duty is just to repatriate the patient back home or we ask for fuel.'
(Respondent 7, pharmacist, psychiatric hospital)

Together with a lack of community services, this means that psychiatry is largely focused on inpatient care and the provision of psychotropic drugs. With no rehabilitation and few interventions to reduce the risk of relapse, the result is that many patients end up back in hospital:

'Our system is such that we are trying to use community psychiatric nurses to trace the patient and try to see to their medication in the home, but that is not enough. The social aspect… our ancestors left us a system where we should have followed up with the social aspect, rehabilitate the patient, see to the patient that the patient is established in society. Now the whole system has fizzled down to our use of the institution and drugs, stabilizing the patient, sending the patient home and then we sit down and wait for the patient to come back. That is what we have been doing. So when you look at

our statistics we looked after about 46,000 patients 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.'
(Respondent 7, pharmacist, psychiatric hospital)

Respondents stressed the need to train more health professionals for mental health in order to reach those in the communities with mental health problems:

'….what I will like to plead to the government is at least they should train more health professionals. So that all the district hospitals will have a psychiatric nurse like here what we do here when they come after now cooling them to a state which they can be referred to anywhere they can be treated. So if we have a psychiatric nurse or a health professional to take care of them at least the roaming on the streets will also be minimized.'
(Respondent 85.4, nurse, focus group discussion, district level)

It was reported that morale is low among workers in psychiatric services due to the lack of resources and the attendant stigma, and attrition is high. Indeed some respondents argued that it was difficult to attract doctors and nurses into psychiatry due to the negative attitudes of other health professionals towards mental health:

'….other doctors [….] they look down upon people who work in the mental health the way they do. It takes great… lots of courage to want to work in that field. So I just basically think that is the attitude of the other health professionals, you know, they discourage anybody who thought about mental health from going to that field. The way they treated our nurses, is the case in point, the way they talk about the psychiatric doctors is a case in point. People come and they leave because some friends tell them: "Why going to mental health?", and they see the way hospital administration, hospital authority treats mental health. Who wants to work with the area like that?'
(Respondent 54, senior academic, regional level)

There was also a real fear of violence from the patients reported by some mental health professionals:

> *'You see people are not attracted to psychiatric because I have learnt from the students that when they come, these aggressive patients, how they attack even verbally and aggressively, destructive, and all these things. When they come in for their rotation they see this kind of action they fear, [……] and sometimes most of our patients have been maimed by these patient, whereby the labour organization doesn't give them enough compensation to keep them going, you see, so if you come to work and somebody…I have a nurse who has got an eye defect because a patient slapped her and up till now the compensation the give her… ..and she is now squinting. So if you see such a thing and they tell you: "This is what a patient did to the nurse", do you thing she will come to psychiatry? It is a dangerous place, very, very dangerous place."*
> *(Respondent 35.3, psychiatric nurse, psychiatric hospital)*

Community psychiatry was deemed to be particularly unable to attract staff due to the lack of resources, especially transport and the fear of attack by patients:

> *'….no transport nothing, rain or shine you are in it, occupational hazard, a lot. Very, very risky. At times you are attacked by your clients. You see our clients are very good once they know us, they accept us when we go, but occasionally one or two may relapse, you are not aware, you go home, the client has relapsed, you are not even aware so that you take precautionary measures. So occasionally you can even be attacked you see'*
> *(Respondent 2, senior psychiatric nurse, regional level)*

In addition there is very little post-basic training available for mental health professionals, and this means the standard of care continues to be compromised. The lack of resources, such as transport, also constrains the capacity of mental health professionals to carry out their work effectively:

> *'….if you are talking in terms of knowledge, they need regular in-service training. They need to know much about the new drugs that*

> *are coming into the system. They need more skills to handle…. and*
> *as I mentioned earlier, they need to be resourced in terms of funds,*
> *vehicles, in terms of a lot of things, so that they can move out to*
> *reach people in the community who are having the problems there.'*
> *(Respondent 31, senior academic psychologist)*

Specialist training in mental health is very limited and mostly non-existent in primary care. Many nurses may complete their training without having passed through any training in psychiatry at all, due to the scarcity of dedicated psychiatric units. This means that not only will they have received no practical experience in mental health care during their training, but that they will have received no exposure to mental health which might stimulate their interest in psychiatry as a specialisation:

> *'The issue is that when nurses are trained they are rotated. Now*
> *during their rotation they have to go through all the programmes that*
> *take place in the health institution. I have already mentioned, apart*
> *from regional hospital no other hospital in this region does*
> *psychiatry. So if the person is not rotated at the regional hospital*
> *and he is rotated through a district, the person finishes his or her*
> *rotation without passing through the psychiatry. Now the idea is that*
> *when the person goes through all this rotation the person will be all*
> *round and then at a point in time the person will say: "I love this*
> *place, I want to do further", but if even the person wasn't taken*
> *through that place, the person has virtually no idea. So the person*
> *may look at other specials, but not look at psychiatry…'*
> *(Respondent 36, regional hospital administrator)*

One respondent suggested that the psychiatric hospitals should be involved in training in mental health for general health care workers at the regional level:

> *'I think that, we should always collaborate with the regional level,*
> *participate in their activities, and is even time to ask them to*
> *organizing workshops so that the specialist here can go there to*
> *fellow doctors to talk to other health workers so that when they are*
> *receiving the mental patient they will know how to go about them*
> *because there are certain problems.'*
> *(Respondent 47, senior staff member, psychiatric hospital)*

Another pointed out the low number of psychiatric nurse training colleges in Ghana and suggested that training in mental health should be incorporated into nurse training schools in the regions:

> '…when we come to the psychiatric schools, we have Pantang and Ankaful. So the schools are not there. …and even look at the schools, the capacity, the infrastructure - inadequate. So even if now we can have within the schools in the regions, if we can have the number of schools we can't create, but we have some schools already. Then can we have some psychiatric courses there, you understand, or the courses we are doing now, can we have mental health taken broader aspect so that people can now come out as specialist in that area in the various schools in the regions?'
> (Respondent 42, senior health educator)

Another suggestion was that community psychiatric nurses should be trained 'hand-in-hand' with public health nurses.

Nonetheless the numbers of training places within psychiatric nurse training colleges and for medical assistants has increased considerably since 2005. The psychiatric nurse training colleges have also conducted some training of cadres of mental health workers with shorter periods of training, such as nursing aids. This has gone some way towards addressing the shortages of staff in the last two years:

> 'In the past we were facing acute shortage of staff because staffs were running away to advanced countries for greener pastures. But thanks be to God, recently the nurses training college here has started training mental health nurses and, luckily for us, come this September the first batch of about eighty will come out to augment the existing staff. And other paramedics are also being trained, like the health aids, which was recently trained about seventy-five of them to help the existing run.'
> (Respondent 48, accountant, psychiatric hospital)

However there are still challenges in retaining such staff, with high levels of attrition from mental health services, either abroad, or to other posts within general medical care in Ghana. Psychiatric nurses who train as medical assistants, for example, often

leave psychiatry to work in other areas of the health service after completing their training.

3.9.4 Intersectoral collaboration

Respondents reported there is very little linkage between mental health and other related sectors, for example in education, the police force and the judiciary. Even in the areas which were felt to be most closely affiliated to mental health, such as Social Welfare, respondents reported a lack of formal collaboration, for example at the level of referrals and multi-disciplinary clinical work.

It was recognised that without the collaboration of other sectors it would be difficult to implement mental health policy. Intersectoral collaboration, for example with the development sector, was seen to be essential in broadening the mental health agenda to address not just the medical aspects of mental disorders, but the socioeconomic consequences:

> *'I think the clearest deficiencies, or the most obvious deficiency is the absence of an up-to-date mental health policy. Not just an up-to-date mental health policy, but a policy that demonstrates linkages to socio-economic aspects of national development or national agenda…..But that notwithstanding, it is just at the level of medical interventions, what happens and all that. So it needs to be extended to include issues of governance, to include issues of the GPRS* [Ghana Poverty Reduction Strategy]*, to include issues of education and what types of life skills education that people need to know as part of their personal development and goals. '*
> *(Respondent 57, director, mental health NGO)*

There is also a lack of intersectoral liaison of mental health with the treatment of other health disorders, despite the evident psychological effects of many physical conditions:

> *Interviewer: '…..what is the extent to which mental health is related to policies from other sectors like HIV, malaria, TB, do we have those intersectoral links?'*

Respondent: 'That is one thing that I think cries for help. Many the people who are going to have these illnesses will have psychological problems alongside. Yet the collaboration, the liaison between us is minimal. So there is not that collaboration, inter-sectoral means or links at all.'
(Respondent 54, senior academic)

Participants expressed the need for education and sensitization on mental health for those working in sectors such as education and the police. Others suggested the need for mental health workers within schools.

Since they are working in the grassroots communities, CPNs were seen to be key workers in developing collaborative ways of working across all sectors, from traditional and faith healers to the police:

'Now if you trained enough community psychiatric nurses who will be able to assist churches or prayer camps wherever they are treating patients, who will be able to assist native doctors who are treating mental patients, help them to see how best they can go about these things. From the grassroots we will be able to progress gradually and reduce the incidence of these conditions before they reach the regional level…..And if you are in the community too, the right of the patients is to be explained so that most of the patients will not be maltreated. If they are in a community they will be able to help even the police to know that: "Yes this man has committed a crime but we know he is psychiatric patient so this what he needs, this will help him".'
(Respondent 55, senior psychiatric nurse, regional hospital)

3.9.5 Implementation of mental health policy and legislation

The initial findings from the WHO-AIMS data indicate the existence of an outdated mental health policy as stated above. A new mental health bill has been drafted to replace outdated legislation. The new law is in line with WHO guidelines on best practice, however it is yet to be passed. Participants felt that the implementation of the law would be an important step forward in providing a mandate for quality mental

health care in Ghana and the protection of the human rights of those with mental health problems. However whilst several respondents felt that the new mental health bill addressed many of the deficits in mental health care in Ghana, including regulating traditional and faith healers, and addressing stigma and social exclusion, some expressed scepticism as to whether there were adequate resources, as well as the political will, to implement the bill once it was passed. A repeated theme among participants is that there is often a gap between policy or legislation and its implementation in practice due to a lack of political commitment or resource constraints:

> *'The problem in Ghana, and it cuts across, the policies will be formulated but the implementation becomes always a problem in every sector. So I'm not surprised that in psychiatry some of these policies they are very nice, nicely framed, but to implement them, some of them, the problems, you understand? There is not much education on mental health nursing to the ordinary Ghanaian, you understand? And even policy implementers, people are not really well informed about mental health programmes. So you find out that even though the policy is there, people will find it difficult to implement them.'*
> *(Respondent 38, psychiatric specialist)*

Several respondents indicated that even the current mental health legislation which has been in existence since 1972 is not being fully implemented, partly due to a lack of awareness of the law.

Suggested barriers to policy implementation were a lack of financial and human resources, poorly defined policies, stigma, and the absence of logistical support to carry out policy directives:

> *'In the regional level, when the policies are out, from my experience what happens is, you will be there, and you are told, or you get a letter that new directive or new policy is being implemented, and this is what you are expected to do. So before that implementation you will not be given any logistics.'*
> *(Respondent 55, senior psychiatric nurse, regional hospital)*

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'One is that the policies in mental health are not very clearly defined. In fact it is only recently that even the bill, mental health bill is being proposed to parliament. I don't even think it has moved from cabinet to parliament level and so that is the case. The absence of a framework for mental health service is definitely a barrier. The manpower resource available is obviously limited, because not too many specialists are in that area. Very few people are interested in that. The stigma attached to the mental health definitely is also a barrier. And then for funding for various services is also a barrier.'
(Respondent 12, programme director, GHS)

Some respondents highlighted the need for intersectoral collaboration and education in implementing policies. They commented on the failure of policy makers to communicate policy decisions at the grassroots and to educate those responsible for implementing policy:

'The first barrier is actually finance, how to get the funds and carry out this activities is a problem, the second one is lack of education. At the community level they are not educated, we need to educate them to understand. And then collaboration. At times there are other sectors who provide health care but they don't work together, [.....] lack of communication is also a factor. So is about financing, and lack of education, and communication.'
(Respondent 47, hospital administrator, regional level)

'…most of the time policies do not get implemented because of sometimes vested interest […]. Secondly, there could also be a lack of consultation, a lack of consultation among key stakeholders such that one major block is left out and they feel very peeved and so even if it is a good policy they will make it seem bad so that everybody will know how important it was to have…done something about it. The third thing is communication. Sometimes the policies are not well communicated, the dialogue, the implementation stage, the communication to go with it is so poor that people do not even see the need for it. The final thing is also to do with ignorance. People actually do not know and so they don't even know that there is a need to do this, this way or that way, and in Ghana generally

> *there is lot of apathy, people do not willingly commit themselves to a course unlike other places where people will say: "We believe in this".*
> *(Respondent 36, administrator, regional hospital)*

Respondents pointed out the need for training if policies were to be implemented effectively:

> *'If you want to implement policies, if it is new, you must give the officers again some kind of re-orientation about the whole policy, the officers must know what is expected of them. You just don't shove it down their throat if they don't know what the whole thing is all about.'*
> *(Respondent 19, Department for Social Welfare)*

Others expressed fears that the stigmatization of mental health might also present a barrier to implementing mental health policy and integrating mental health into public health:

> *'….not all the people who are interested in mental health, especially most of the public health doctors, people who study public health, you mention mental health and you are just ignored because you're not dealing with good people or normal people, so they try to stigmatize the institution'*
> *(Respondent 13, Health Research Unit)*

It was suggested that there should be greater consultation with those responsible for implementing policy at the grassroots level in order to discuss any barriers to implementation, and gain greater cooperation in implementing them:

> *'So before this document comes in and given you the order that you should implement it, there should be some kind of workshops so that people will meet each other in a think tank situation where you know that this is what they are going to implement and from what I see this is the problem which we are going to face……Now if all those people who are part of the policy…. implementation of the policy undergo such workshops over time and they are allowed to*

> *express themselves freely: "What do you see as a problem? What do you see as the way forward?", probably an amendment or modification could be done on the policy which is going to be implemented '*
> *(Respondent 55, senior psychiatric nurse, regional hospital)*

However, despite the barriers to mental health policy implementation, it was acknowledged that some moves towards developing mental health services in Ghana had already begun with the opening of regional psychiatric units and the drafting of the new legislation. Therefore structures are already in place onto which it is hoped the new services can be grafted:

> *'….we are not taking off from zero, the structures are there already and we are only trying to improve upon it, and I think the government has also recognized mental health as a priority in the next Programme of Work, so I think some resources will be put in the place.'*
> *(Respondent 16, World Health Organization, national level)*

3.9.6 Summary

The potential benefits of moving mental health care away from the psychiatric hospitals and into community-based services was recognised by almost all participants. However it was felt that currently mental health was poorly integrated with primary care, and mental health service delivery remained centralised within the psychiatric hospitals. It was suggested that mental health care could be incorporated into existing public health initiatives such as CBR (Community-Based Rehabilitation) and CHPS and that all primary care doctors should be able to treat mental illness, particularly less severe conditions, such as moderate to mild depression. This would help to remove some of the stigma associated with attending the psychiatric hospitals. Some respondents supported the need for public education to promote mental health at the community level.

Respondents commented on the value of community–based mental health care in supporting the integration and rehabilitation of those with mental health problems. However the decentralisation of mental health care was acknowledged to be only

partially achieved, with an unequal distribution of regional psychiatric units across the country with the north remaining the most neglected area. Community mental health services which are in existence are often restricted in the quality of the service they are able to deliver due to a lack of sufficient staff and resources. There are almost no facilities for rehabilitation in GHS in the form of rehabilitation units (half-way houses) or day centres.

There are limited numbers of mental health professionals, and many of those who are currently employed are due for retirement. There are very few psychosocial health professionals such as psychologists and OTs. The 'brain drain' has also had a severe effect on the retention of health care workers in Ghana, particularly in psychiatry. Low morale, fear of violence from patients, and the stigma towards mental health means it is difficult to attract health workers into psychiatry. The lack of personnel and the limited amount of post-basic training means the quality of mental health service provision is severely compromised. Mental health care remains largely curative with very little focus on rehabilitation or relapse prevention.

Participants identified the need to develop more regional units for mental health as well as rehabilitation facilities to promote social inclusion. There is a need to train more health professionals, and to provide training for primary care workers in mental health.

There is little intersectoral collaboration in mental health between stakeholders such as the police force, the judiciary, social welfare and education. There is also limited liaison with those providing general health care to the mentally ill. Intersectoral collaboration was seen as essential for the successful implementation of policy and to address the socioeconomic consequences of mental illness and participants identified a need for education and sensitization in mental health across all disciplines. CPNs were seen to be crucial in developing intersectoral links at the community level.

Many respondents expressed support for the draft mental health bill which it was felt promoted quality mental health services at the community level, and the protection of the human rights of the mentally ill, and urged that it should be passed into law. However many also expressed some concern about how far the bill would be implemented once it was passed into law. Possible barriers to policy implementation included a lack of human and financial resources, stigma towards mental health, a

lack of political commitment, and a failure to communicate policies to those responsible for their implementation. In order to enhance the implementation of policy, participants stressed the need for intersectoral collaboration and consultation, as well as education and training for health care workers and other stakeholders.

3.10 Research

There is very little published research in mental health in Ghana and no dedicated journals for mental health. Between 2000 and 2005, 3 articles were published on mental health in Ghana as identified on PubMed. These were a survey of resource utilisation for mental disorders (Ferri et al. 2004), a survey of help-seeking behaviour for mental illness in Kumasi (Appiah-Poku et al. 2004) and an overview of the mental health situation in Ghana (Roberts 2001). This represents about 1% of all articles on health in Ghana as identified on PubMed. Other articles on mental health were published in journals which are not part of PubMed, including the Ghana Medical Journal. These include a survey of the use of traditional healers for mental health (Osei A 2001a), a study of depression among those accused of witchcraft (Osei A 2001b), a study of the prevalence of psychiatric disorders in an urban community (Osei A 2003), and a study of drug compliance among psychiatric patients (Mensah & Yeboah 2003). There was no research on biology and genetics, policy and programmes in mental health, nor on financing and economics. Since 2005 there have been some research publications in indexed journals on homelessness and mental health in Accra (De-Graft Aikins & Ofori-Atta 2007), and on family carers of people with mental health problems in rural and urban areas of Ghana (Quinn 2007).

Mental health is not a priority area for research in the three health research institutions in Ghana. Currently only one out of the three health research institutions in Ghana is involved in community-based mental health research. This includes risk factors for schizophrenia in rural Ghana (Doku 2005), validation of postnatal depression screening measures (Weobong et al. 2008), psychiatric disorders in the elderly (Akpalu et al. 2007), and an anthropological study of living with mental illness (Read 2006).

One respondent noted that the lack of research in mental health constrained the capacity of research to influence policy. He noted the lack of research capacity within mental health in Ghana due to the lack of personnel:

> *'I'm afraid to say this but there is not a whole lot of research going on in mental health. For one thing for lack of personnel we do not have the people who have the capacity to do the research in the area of mental health. So I'm sure the little that goes on makes some impact with us but is not the whole going on so is hard to tell.'*

Research priorities in Ghana may also be driven by external agencies who provide the majority of research funding:

> *'…..I think for those in research without them* [NGOs, donors] *we don't exist because we don't get…we get very little support from our own governments. If you take this centre for instance we depend on donor money. So they are extremely important.'*
> *(Respondent 18, senior health researcher)*

Some respondents acknowledged the need for research in mental health in order to promote evidence-based practice. However one senior researcher highlighted that research within Ghana was only one method for generating evidence for health care policy. Health care policy could also be based on comparable research from outside, as well as best practice:

> *'Evidence generation is not only through systematic research. Research is one form of generating evidence, but there are several things: anecdotal evidence can be made available through people's observations and all that. So as much as possible we try to ensure that the policies that we formulate are based on evidence. The evidence is not necessarily generated from in-country. If there is ample evidence from the literature from studies that have been done in several parts of the world that have a very similar situation that we have, we don't need another set of evidence before we can do that…… so the issue is: what is the best practice? And the best practice as we know historically, anecdotally and also from what do we call it…..from research as well, so it is combination of issues……I mean research in an ideal condition is different from implementation. So these are the things that one needs to bear in mind when we are talking about evidence. But as much as possible we try to make up policies based on evidence that is available.'*
> *(Respondent 5, senior health care researcher)*

Despite the presence of formally defined lists of individual data items that ought to be collected by all mental health services, the extent of data collection is variable among

mental health facilities. The government health department received data from the 3 psychiatric hospitals, 4 community-based psychiatric inpatient units, and 64 mental health outpatient facilities.

This participant noted the lack of efficiency and reliability in gathering data on mental health in Ghana which impairs the ability to argue for greater priority for mental health:

> *'Evidence, the statistical collection of data itself has a problem, we don't have a statistical data bank that we use in convincing people because psychiatry in this country is about 100 years old yet still it's always been sidelined. It has not been run at that meticulous efficient manner in which we have a database for arguing our things out. We always use the obvious, observed, that is what we do. But we don't as yet see a database, our record department itself even is not on its feet. Figures coming out from those places can easily be challenged. We have the three institutions. We don't have coordinated records department. The activities are not well coordinated, we have not built the base for making argument from that angle.'*
> *(Respondent 7, pharmacist, psychiatric hospital)*

However one participant pointed out that even when data was collected it did not seem to influence policy as resources remained far below what was indicated by the data:

> *'….looking at our data, the number of patients that pass through our hand every week, every month and quarterly, you can find out that if they have been using the evidence here they will give us more doctors, more psychologists….*
> *(Respondent 1, senior nurse, psychiatric hospital)'*

One psychiatric health professional complained that although plenty of research may be done, few of the results were disseminated for the development of mental health:

> *'… sometimes this kind of research is done everywhere, day in, day out, we do the research, but we don't find anything coming from it. It*

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is kept in the shelves and even no books come out for people to know that this is such a kind of research has been done for the benefit of the patients and improve staff knowledge. I think this research something should be done about it and printed out, whether giving handouts for people to know what is happening, rather than keeping all that research that we do, keeping under the shelf and nobody sees anything about it.'

(Respondent 35.3, psychiatric nurse, focus group discussion, psychiatric hospital)

3.10.1 Summary

Whilst participants noted the need for research on mental health in Ghana, including the maintenance of accurate data within psychiatric services, it was evident from responses together with the Pubmed search that there is limited research activity on mental health in Ghana. Data collection within psychiatric services is neither systematic nor comprehensive. Therefore there is a lack of reliable data on mental health to inform the development of mental health services. What research is done is not sufficiently disseminated and taken up in policy.

4. Discussion

4.1 Context

Participants situated mental health care within the context of current health policy emphasising the 'doorstep delivery' of health care at the community level. Public health provides a model for how mental health care might be delivered in Ghana, involving community stakeholders from local health care personnel, to traditional authorities and family members. Yet existing structures for public health initiatives often exclude mental health from their agenda. Nonetheless the need for mental health promotion and education in improving the health of the nation was acknowledged by many participants in this study.

Participants also recognised the unequal distribution of health care resources within the country. The rural areas of Ghana, particularly those in the north, are those which suffer from the highest levels of poverty. 45.4% of the population of the rural savannah areas of Ghana are estimated to be living in 'extreme poverty' as compared to 2% in the urban coastal areas (Government of Ghana 2007b). Mental health service delivery is itself concentrated in the urban areas of the south which have the highest number of facilities and health professionals. If mental health care is to reach the poorest sectors of the population then it is these regions outside of the cities which need the greatest concentration of resources.

The Ministry of Health has explicitly linked improving the health of the nation to economic development stating its commitment to improving human capital by "creating wealth through health"[2]. However despite growing evidence of the link between poverty and mental illness, respondents observed that mental illness remains excluded from the development agenda. Given the high burden of disease in the country, mental health competes with conditions such as malaria, HIV, tuberculosis and other conditions with potentially high mortality and morbidity. Yet many of these conditions have potential consequences for mental health, and mental health itself increases the likelihood of poor physical health (Prince et al. 2007).

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[2] Quotation taken from the website of GHS www.ghanahealthservice.org

WHO's mantra of "no health without mental health" does not appear to be widely acknowledged in the prioritising of health funding in Ghana.

The need to promote and protect the human rights of the mentally ill was another topic discussed by many participants, who noted the widespread abuse of the mentally ill in Ghana. Unfortunately, this is not limited to traditional or faith healers, but extends into the psychiatric hospitals themselves. Yet as with development policy, mental health does not appear to be central in human rights promotion in Ghana. Current mental heath legislation does little to protect the rights of those with mental illness and existing human rights bodies in Ghana such as the Commission for Human Rights and Administrative Justice do not prioritise human rights abuses against the mentally ill in their activities. Whilst traditional and faith healers were acknowledged by participants to play a valuable role in psychosocial and spiritual treatment for mental disorder, the mentally ill are often subject to abuse whilst in the care of such healers. Many of these abuses remain unreported and in the absence of any system for monitoring and regulating the activities of healers, the mentally ill continue to suffer in silence, many hidden away in prayer camps and shrines. Regulation of healers would not only help to protect the mentally ill from abuse, but also open the way for collaboration between traditional and faith healers and biomedical practitioners, drawing on the respective skills of each.

4.2 Mental Health Situation in Ghana

Responses indicated that mental illness in Ghana is widely associated with the abuse of drugs, in particular cannabis. This has implications for the public perception of mental illness, since drug use is morally sanctioned and its association with mental illness can lead to the mentally ill being viewed as criminal and morally suspect (Gureje et al. 2005). This perception is often reinforced by spiritual interpretations of mental illness in which it can be seen as retribution for immoral behaviour. Mental illness is also associated with aggressive and violent behaviour and there is widespread fear of the mentally ill. This association of mental illness with madness and violence, means that 'quieter' forms of mental illness may be overlooked, whilst the more florid forms of psychosis are quickly taken to hospital. This has consequences for the mental health of women who are seen to suffer more from depression as a result of marital problems, the stresses of providing for children,

discrimination and domestic violence. The role of social factors in the aetiology of depression in women (Turkson & Nortey Dua 1996) may mean that their mental health needs receive less attention within mental health services, and it is likely that many of those suffering from depression and other common mental disorders receive no treatment from mental health services.

Respondents acknowledged that mental health is seen as a low-priority area within the health system in Ghana as compared to other areas of health care delivery in the country. Responses suggest that given the high disease burden in Ghana and the competing demands for resources, mental health struggles to be included in health care priorities. However policy makers recognised that mental health places a considerable burden on individuals, their families and society, and that there is a large unmet need for quality mental health care. The low priority of mental health has implications for the allocation of funding, and the provision of services. Raising the priority of mental health in the context of limited resources presents challenges to ensure that funds are directed towards those who are most in need. High quality mental health care would ultimately prove more efficient through reducing the rates of readmission, preventing relapse, and addressing risk factors for mental illness.

The need to address the 'vicious cycle' of mental health and poverty (Patel 2001) was recognised by participants. Several participants suggested that poverty could lead to 'thinking too much' which could in turn lead to mental illness, thus suggesting an association between poverty and depression and anxiety. Tackling poverty and mental health go hand in hand, since the effects of mental illness can reduce productivity. Improving the person's ability to return to supporting themselves and their families has economic benefits for the individual and the community.

As this study shows stigma towards mental illness is pervasive in Ghana and has lead to the exclusion of those with mental illness at all levels of society. Many of the participants themselves showed stigmatizing attitudes towards the mentally ill, especially towards vagrants who were seen as making the streets dirty and unsightly. Stigma contributes to the continuing low priority of mental health and to the morale of staff, who feel ostracized by fellow health professionals. Stigma impinges on the human rights of the mentally ill, yet tackling stigma in mental health can be notoriously difficult (Crisp et al. 2000). However campaigns have already commenced through NGOs such as Basic Needs and Mindfreedom to enhance the

acceptance of those with mental illness within their communities and to promote social inclusion.

The involvement of users of mental health services in policy-formulation is key to creating policies which meet the needs of those affected. However such is the stigma towards mental illness that such consultation processes rarely occur. There is a need for advocacy organisations who can promote the involvement of those with mental illness and their families at all levels of mental health policy and planning.

4.3 Process of Mental Health Policy and Law Development

Responses indicated that the gap identified by participants between ideology and practice in policy-making was replicated in the development of mental health policy. Whilst the formulation of mental health policy received a high level mandate from government, there has been a failure to conduct consultations with grassroots stakeholders, in particular with users of mental health services and their carers. Consequently those responsible for implementation, particularly at the district level, felt excluded from the process of policy development and so may be less likely to be committed to implementing policy directives. There was also a lack of intersectoral consultation at the ministerial level which compromises the involvement of other agencies in mental health care initiatives and may also make them less committed to their implementation.

However the draft mental health bill was praised by participants for the extensive consultation process in its development and sets a standard for processes of consultation in the formulation of policy and legislation that could work as a model for other countries in the region.

4.4 Appropriateness of Mental Health Policy and Law

Current mental health policy and legislation were acknowledged to be out of date and failing to meet standards for best practice in mental health. Despite long-standing commitment in mental health policy to the principles of decentralisation, the development of community-based mental health care, and the training of mental

health professionals, there has been only limited progress towards these goals. There appears to be have been insufficient attention to the sources of funding to meet the objectives of mental health policy.

The Mental Health Decree which provides the current legal framework for mental health in Ghana has no provisions to promote the rights of those with mental health problems and makes no reference to the provision of community-based services. The new mental health bill should be passed a matter of urgency as this would be a major step in providing the legal backing for mental health policy, and provide a mandate for the development of community-based services. It would also establish the necessary monitoring of mental health service provision to protect the rights of patients and their carers, particularly those under involuntary admission. In addition it would make provision for the regulation of traditional and faith healers. The passing of the mental health bill therefore should be the first step in enhancing mental health care delivery in Ghana, bringing mental health legislation into line with international standards on human rights and best practice in mental health.

Several policies and pieces of legislation which have recently been introduced in Ghana are directly relevant to mental health care in Ghana such as the Domestic Violence Act and the Disability Act. However this legislation makes very little explicit reference to mental health and mental health is not generally recognised as falling within the scope of terms such as 'disability', 'vulnerability' and 'social exclusion'. Therefore existing policy and legislation which could work to promote the human rights of the mentally ill is not implemented. Mental health is also not included within poverty alleviation policy, despite the fact that those with mental illness can be some of the most excluded and impoverished members of society.

4.5 Mental Health Implementation at National and Regional Levels

Mental health care provision in Ghana remains highly centralised, with the majority of mental health expenditure being absorbed in the upkeep of the three psychiatric hospitals. The position of the Mental Health Unit within the Institutional Care division, highlights the historical legacy of mental health care in Ghana, where asylums still function in part as custodial institutions, as witnessed by the high number of long-stay

patients, including many detained by order of the courts. Community-based mental health services, such as rehabilitation or vocational training centres, are unavailable to the majority of those with mental health problems.

There are insufficient numbers of mental health professionals at all levels of the health care system, with most concentrated within the psychiatric hospitals. This means there is limited availability of specialist mental health care in much of the country, especially outside of the southern regions. The paucity of mental health professionals has implications for quality of care and the safety of staff and patients. The lack of professionals with training in psychosocial interventions such as psychology, social work and occupational therapy, means that there is very limited provision of psychosocial care and rehabilitation. The high numbers of long-stay patients reflect the need for rehabilitation to enable some of these to return to the community.

Psychotic disorders are reported to be the most common diagnosis in the psychiatric hospitals in Ghana, with substance abuse the second most common diagnosis. Common mental disorders such as depression and anxiety, form a much smaller percentage of the caseload in the psychiatric hospitals and it is probable that many of those with these disorders are unseen by mental health services. As women and older people are more likely to suffer from these disorders it is likely that the current mental health services are not equally reaching these groups.

There is a very limited range of psychotropic drugs available in Ghana, with few atypical anti-psychotics or SSRIs available at most mental health facilities. There are problems of supply with even the most standard drugs such as Chlorpromazine, both within the psychiatric hospitals and community services. The problems of supply, coupled with the side effects of many anti-psychotic drugs are likely to worsen the likelihood of continued adherence to psychotropic medication on the part of patients, thus increasing the risk of relapse.

4.6 Mental Health Policy Implementation at the District Level

The overview of mental health services within Kintampo district reveals the challenges for the provision of mental health care at the district level and the impact of centralisation of mental health care and the limited availability of community care.

The district is not untypical in Ghana in having no resident mental health professional, and no dedicated facilities or resources for mental health. Treatment for mental illness is therefore restricted to the district hospital which has a limited supply of psychotropic drugs. Where necessary referrals are made to the regional or national psychiatric services. However there are no facilities for follow-up. Consequently the burden of care for those with mental illness largely falls to the families.

Attitudes to mental illness in Kintampo are representative of attitudes throughout the country and reveal the social exclusion of the mentally ill in all aspects of life, from work to marriage. In this example poverty and stigma can be seen to work hand in hand, therefore resulting in a double burden of disadvantage for those with mental illness.

Government sectors in the district such as schools, the police and social welfare lack the skills and resources to work effectively with those with mental illness, with mental health policy and legislation having virtually no impact at the district level.

In the absence of psychiatric services in districts such as Kintampo, traditional and faith healers remain the major resource for the treatment of mental illness at the district level. Some healers expressed their willingness to collaborate with mental health professionals in the treatment of those with mental illness. The perception of mental illness as often spiritually caused, and the potential psychosocial benefits of traditional healing, suggest that traditional healers and faith healers may prove an important component in developing community-based treatment for mental illness at the district level. Recent initiatives by Basic Needs to provide training in mental health for traditional healers and support their collaboration with CPNs have proved successful and could provide a model for more widespread efforts in training and collaboration.

4.7 Key Issues in Mental Health Service Implementation in Ghana

There was overwhelming support among participants for the decentralization of mental health services. Many argued forcefully for the need for mental health care at the community level and the integration of mental health into primary care.

Community-based services should help to reach more of those in need, as well as remove some of the stigma attached to the psychiatric hospitals. Community-based treatment also facilitates the reintegration of the individual into the community once he or she has recovered, rather than removing the person to the psychiatric hospitals for long periods of time. Over the years several attempts have been made to train community level workers to recognize and refer cases of mental illness, and to train primary care workers in mental health. Most recently Basic Needs is involved in such programmes in the north of the country and in Accra. These initiatives have increased the detection and treatment of mental illness and suggest a need to expand such initiatives to all the districts and ensure their sustainability in the long term. Unfortunately such schemes are often dependent on outside funding and therefore tend to come to an end when funding is no longer available.

Participants acknowledged the difficulties of recruitment and retention of workers in psychiatry. Ghana has begun to address the shortage of nurses through expanding the intake of the psychiatric nurse training colleges. However there is also a need to address problems with staff morale and retention. There are high rates of attrition among mental health professionals, both internally and externally. Many community psychiatric nurses are nearing retirement and there is an urgent need to plan for their replacement[3]. Post-basic training in order to enhance the skills of psychiatric professionals is rarely available and there are limited opportunities for professional development within the country. An investment in the ongoing training of mental health workers would help to maintain the standard of care as well as potentially enhance the morale of staff.

Intersectoral collaboration was acknowledged to be poor and yet it was recognised that such collaboration was vital for the successful implementation of mental health policy and legislation. Workers in mental health at the community level, such as CPNs, can pay a pivotal role in developing intersectoral links at the community level. Without such community-based professionals to advocate for mental health, it is unlikely that other sectors will take the initiative in mental health as they are already over-stretched and are unlikely to wish to attract further work.

Despite strong support for the ethos of the Mental Health Bill, many respondents expressed scepticism about whether there would be a sustained commitment to

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[3] Since 2005, the number of CPNs has decreased from 132 to 115.

implement it in practice. Participants identified many barriers to the implementation of the Mental Health Bill including a lack of resources, stigma, and the failure to train and educate those responsible for its implementation at the service delivery level. Participants' responses serve to caution that without the necessary political will and a commitment in terms of human and material resources, there is a danger that even once passed, the Mental Health Bill could share the fate of many other valuable pieces of legislation which remain poorly implemented in practice.

4.8 Research

There is a lack of systematic and routine date collection on mental health at all levels of the health system, particularly within primary care. The lack of reliable data on the numbers of cases presenting with mental health problems at the primary care level means that it is difficult to argue for mental health to be addressed in service planning.

There is some amount of published research both in reviewed journals and in the grey literature, but very little research is sufficiently disseminated and the findings have rarely been taken up in policy. There have been few population-based epidemiological studies to reveal the true extent of mental health problems in Ghana. Most of the psychiatric research in mental health has utilised hospital-based samples where often only the most severely ill and more behaviourally disturbed are admitted. Building research capacity in mental health could help to provide an accurate evidence base on which to develop future mental health policy.

4.9 Areas for action

The combined results of the WHO-AIMS, documentary analysis of mental health policy and legislation, and the qualitative interviews and focus groups suggest the following areas to be addressed in mental health policy and service delivery in Ghana:

4.9.1 Mental health situation

- o Popular knowledge of mental illness in Ghana associates mental illness with madness. Common mental disorders such as anxiety and depression are much less recognised. Awareness campaigns should therefore be mounted to

expand the knowledge of the general population and target groups who are likely to have contact with such disorders such as teachers, police officers, prison officers and magistrates, as well as those most at risk of common mental disorders, in particular women and older people.

o Women are at risk of mental illness due to discrimination, the burden of childcare and domestic violence. Empowering women and tackling domestic violence through education and advocacy is therefore important in addressing the mental health of women in Ghana.

o Affirmative action is needed to raise the priority of mental health through public education and awareness campaigns. NGOs are well-placed to work alongside mental health services in promoting mental health and public awareness, and lobbying for the inclusion of mental health in policy.

o Stigma towards those with mental illness is pervasive in Ghana and extends to all sectors of society. Anti-stigma campaigns should therefore be extensive and regular to address discrimination against those with mental health problems and to foster social inclusion. These campaigns should include users of mental health services in their planning and delivery, and could draw on the lessons of campaigns on HIV/AIDS and people with disabilities.

o Human rights abuse of the mentally ill is not only seen in traditional and faith healing facilities where the most obvious abuses are the chaining of patients, but also in the psychiatric hospitals, for example in the use of unnecessary seclusion and restraint, and unsanitary and overcrowded conditions. There is a need for regular inspection and monitoring of all psychiatric facilities, public and private, to enforce the protection of the human rights and the dignity of those receiving treatment. Traditional and faith healers should be registered and their healing practices regularly inspected and monitored. Sanctions should be in place for those healers who fail to protect the rights of their patients.

4.9.2 Mental health policy

o Many of those with mental health problems in Ghana are recognised to be from among the poorest sectors of society. It is known that mental illness and

poverty are mutually reinforcing. Therefore mental health should be specifically incorporated into strategies for poverty alleviation and development. Mental health care should go hand in hand with interventions to address poverty such as income generation schemes and vocational training.

o There is a need to update mental health policy to bring it into line with draft mental health legislation. More extensive consultation should be conducted with stakeholders, particularly at the grassroots level, from the start of the policy-making process through to its implementation and evaluation. Consultation not only ensures that policies are relevant and feasible, but helps in the effective implementation of policies and plans.

o Barriers to the implementation of mental health policy need to be addressed. Mental health policy should be widely disseminated within GHS and in other relevant sectors. Training in the content of mental health policy for all those affected by the policy should be provided in order to raise awareness and ensure policy is implemented. There is also a need to identify the sources of funding for planned initiatives and for a significant investment in mental health services if the objectives of mental health policy are to be fulfilled.

o User participation is very limited in Ghana, and is an important step in helping to combat stigma and protect the human rights of those with mental illness. There is a need to form user advocacy groups and for mental health service users to be consulted in mental health policy formulation and in the monitoring of mental health services

o It is crucial to lobby for the speedy passage of the 2006 Mental Health Bill into law. The bill touches on many of the areas for action mentioned in this discussion, and its passage would provide a mandate to address some of these issues to improve mental health care delivery in Ghana. However there needs to be an equal commitment in terms of resources and political support if the bill is to be implemented once it is passed.

o Mental health policy and legislation should not be viewed in isolation, but should be promoted in the context of other relevant legislation and policy in order to maximise the inclusion of mental health within national policy.

4.9.3 Mental health service implementation

o National health policy in Ghana emphasises de-centralisation and increasing access to care through an emphasis on primary care and health promotion at the community level. To facilitate mental health promotion and case detection at the community level, mental health could be incorporated into existing structures for public health delivery, such as CHPS and Community-Based Surveillance Volunteers (CBSVs). Cadres of public health workers such as Field Technicians, CBSVs and CHPs volunteers could serve as resources for identifying cases of mental illness at the community level drawing on previous experiences in the training of such personnel in case detection and referral.

o Given the link between poverty and mental illness, and the concentration of mental health facilities and health professionals in urban areas, there should be a focus on extending mental health services to reach those in the poorest sectors of society in rural areas, particularly in the north of Ghana.

o There are problems of supply with essential psychotropic drugs, both within hospital and community services. The number of drugs available to treat mental disorders are limited and largely restricted to older drugs with more severe side effects. There is a need to improve the supply of psychotropic drugs and to consider the purchase of newer drugs, such as atypical anti-psychotics, so as to provide a high standard of treatment and optimise quality of life for those with mental illness.

o There is a lack of intersectoral collaboration in the provision of mental health services. There is a need for closer collaboration among agencies involved in the care of the mentally ill, and for training in mental health for those such as social workers, the police and teachers.

o The quality and availability of mental health care is severely constrained by the low numbers of mental health professionals and the limited opportunities for professional development. There is a need to provide effective support and supervision, as well as opportunities for ongoing training, in order to retain staff. Training of Psychiatric Clinical Officers has worked effectively in several African countries and should be considered in Ghana. More psychologists, social workers, occupational therapists and other health

professionals should be trained and employed in mental health services in order to provide psychosocial interventions in mental health care.

o There is a need to improve the quality of inpatient psychiatric care. The psychiatric hospitals are in need of renovation to provide a safe and comfortable environment for patients and staff. More effective and comprehensive treatment for psychiatric patients, including rehabilitation and other psychosocial interventions, as well as the provision of community mental health care, could assist in easing congestion in the hospitals through limiting the length of admission and preparing patients for discharge.

o The establishment of community-based mental health care is vital to reach those living in the districts and to provide follow-up on discharge from hospital. Community–based care should include psychosocial rehabilitation and vocational skills training to assist the person to acquire the skills to enable them to reintegrate into society and support themselves in the community where possible. Psychosocial rehabilitation could also prevent the acquirement of disability from mental illness.

o Mental health care should be integrated into primary health care delivery at the district level. Mental health should be incorporated into the training for all primary health workers, and training should include a practice placement within mental health services.

o There is a need to develop effective mechanisms for the follow-up of patients once discharged to the community. Communication between psychiatric hospitals and community-based services should be improved with all patients being referred to local services for follow-up.

o Psychiatric units should be opened in all the regional hospitals. There is a need for regional psychiatric units to develop greater integration and collaboration with services at the district level. The regional units could serve as resources for mental health training, both in terms of practice placements for health care trainees, and in terms of outreach to other health services as well as other relevant sectors in the districts.

o There is a need for a dedicated budget for mental health at the regional and district levels in order to facilitate the delivery of mental health care within local communities.

o Traditional and faith healers are an important resource in the care of the mentally ill. There is a need for greater collaboration and consultation between psychiatric services and traditional and faith healers in order to work together to provide effective mental health care. Consultation on ways forward for collaborative working with traditional and faith healers should be initiated, drawing on lessons from previous co-operation between traditional healers and medical practitioners in Ghana and elsewhere in Africa.

o The burden of care of the mentally ill falls on families who receive little support. Education and support is needed for family members as well as assistance for them to access mental health services when needed, for example in providing assistance with transport to hospital.

4.9.4 Research

o There is a need for systematic and routine collection of essential data within mental health services. Much vital data is unavailable due to poor record-keeping and the lack of standardisation in recorded information. There are very few records collated for psychiatric cases seen in primary care or in general hospitals. Essential data on items such as numbers of patients seen, length of admission, and number of cases secluded or restrained should be collected routinely to allow for audit and research to inform mental health plans and policy

o There is a need to produce high quality research to provide an evidence base for the development of mental health policy and service delivery.

4.10 Challenges and Limitations of the Study

This study presented a number of challenges and limitations. There were considerable difficulties in obtaining interviews with all the relevant stakeholders, particularly at the more senior level where prospective interviewees had very busy

schedules. Some declined to be interviewed. This meant that the team was unable to conduct interviews with some of the key stakeholders at the macro level, for instance with the Minister of Health. Many of the respondents at the meso and macro levels also granted limited times for interviews which meant that the interviewer was unable to ask all the questions on the interview schedule, and there was insufficient time to probe topics in depth and seek clarification. Given time, there may perhaps have been more in-depth information gathered as well as the broad overview in this report.

Limitations in infrastructure impacted on the capacity of the research team through difficulties such as obtaining reliable telephone contact, power failure, poor roads and irregular public transport. Whilst the district site has many advantages for a study of mental health policy implementation at the micro level, the distance from the capital meant that considerable time was expended in visiting the capital in order to conduct interviews with stake holders at the national level.

The WHO-AIMS is a particularly lengthy document and given the resource limitations it proved impossible to gather information for all the domains within the specified time. In addition much quantitative data is simply unavailable because it is not routinely collected. Thus many important statistics were not available. There are also weaknesses in the current health information system which resulted in a number of difficulties such as inconsistencies in data collection between services, possible double collations of numbers from the district to regional levels, different categories and labelling of the same data, and different definitions for the same categories of information at different collection points. These made it difficult to interpret what little data existed.

There were considerable difficulties in fitting local data into the categories of the WHO-AIMS. The service categories in particular reflect service provision and structure within higher-income countries, and did not clearly reflect the situation within Ghana and may have led to some distortion of the data.

The sampling of the respondents was drawn largely from the southern part of Ghana due to the location of the capital city and the three state psychiatric hospitals in the south. This meant that fewer stakeholders were sampled from other regions in the country, including the three northern regions. This restricts the scope of the research, in particular in respect of those regions which are most remote from the centres of government and of psychiatric services.

The district level site selected, Kintampo district, may also have presented some limitations to the study. Although it is not untypical in having no dedicated mental health worker, other districts where there is more mental health provision would have inevitably produced different results at the micro level. Kintampo is also a DSS site and the location of a number of research projects conducted by Kintampo Health Research Centre, therefore the population is over-researched which may have some impact on the findings.

Unfortunately due to time and resource constraints very few users of mental health services were interviewed, nor their families. This is regrettable as their viewpoint is crucial to an understanding of the needs of those with mental illness and their families. It is hoped to conduct further interviews with users of mental health services in subsequent stages of the project.

For the interviews and focus groups, the process of transcription and translation was time-consuming and required the recruitment of additional staff to assist with the process. Staff recruited to transcribe the Twi interviews were not trained in interview transcription and did not transcribe interviews verbatim which may have compromised the accuracy of the content. There was also the challenge of translating concepts into English that may have had no exact translation. This means that at times the meaning of participant's comments may not have been adequately conveyed. Unfortunately time did not permit a process of rigorous translation and back-translation which may have helped to ensure greater accuracy in translation.

5. Conclusion

5.1 The Ghanaian Mental Health System: Strengths, Weaknesses, Opportunities and Threats

This overview of the mental health system in Ghana has highlighted the challenges facing the provision of quality mental health care to those living with mental illness in Ghana. The following strengths and weakness and opportunities and threats facing the mental health system in Ghana have been identified:

5.1.1 Strengths

- o Some moves towards de-centralization of mental health care have begun with the opening of psychiatric units in the regional hospitals and the establishment of community psychiatric nursing services. Mental health has been integrated into all the Regional Health Management Teams and into those District Health Management Teams where community psychiatric nurses are in post.

- o Initiatives through NGOs and other agencies to enhance the community detection of mental illness and provide treatment have met with some success and draw on the availability of public health workers at the sub-district level.

- o There are an increased number of training places available for psychiatric nurses and other health professionals such as medical assistants.

5.1.2 Weaknesses

- o Uneven distribution of mental health services throughout the country limiting access to treatment.

- o Lack of human resources at all levels, including inpatient hospitals and community services. It is difficult to attract health professionals into psychiatry due to stigma, low priority of mental health, and fears of violence.

o Little opportunity for continuous professional development for mental health professionals.

o No training and support for other sectors in contact with those with mental health problems, such as teachers and police.

o Very few community-based mental health services and mental health professionals, and little integration of mental health within primary care. Poor communication between psychiatric services and primary care, leading to a lack of effective procedures for follow-up of discharged patients within the community.

o Very few rehabilitation facilities for mental health in Ghana. Treatment for mental health largely curative. Very few psychosocial professionals in mental health care and a lack of rehabilitation and psychosocial treatment for mental health.

o Poor quality of care and human rights abuses in both government facilities and traditional and faith healing facilities. No regulation and monitoring of traditional and faith healers and stigmatization towards patients at the institutional level.

o Services are focused on treatment for severe mental disorders. There is little focus on treatment for common mental disorders at the community level.

o The majority of dedicated funding for mental health is absorbed by the psychiatric hospitals.

o No consultation with users of mental health services, their families, and health professionals at the district level in the formulation of mental health policy.

o Limited intersectoral collaboration with other agencies such as the police and education, in the development of mental health policy.

o Little implementation and dissemination of existing mental health policy.

o Little reliable data gathering and dissemination of research to inform mental health policy and planning.

5.1.3 Opportunities

o There is widespread acknowledgement at the macro level of the need for de-centralisation of mental health service provision and the development of community-based services.

o A new mental health law has been drafted which draws on extensive consultation at all levels of society, including users of mental health services, and which is consistent with WHO best practice guidelines. If passed, the law would signal a new standard for mental health care in Ghana and provide a mandate for improved services

o There has been considerable collaboration and support for mental health in recent years from international agencies such as the Royal Netherlands Embassy and the World Health Organization. There has also been a growth in the number of both international and local NGOs in the field of mental health.

o Large numbers of traditional and faith healers offer treatment for mental illness at the community level and are well-placed to provide psychosocial and spiritual support. Some have indicated their willingness to collaborate with biomedical services.

o There has been renewed impetus to further the cause of mental health in Ghana through research and advocacy. There is increasing research in mental health in Ghana which could raise the profile of mental health and provide an evidence base for further service development.

o Public concern regarding rising rates of drug abuse has drawn increased attention to mental health issues.

5.1.3 Threats

o Pervasive stigma, both at the societal and institutional levels, towards patients, their families and staff in psychiatric services.

o Low priority of mental health in government policy, with mental health often overlooked in other relevant policy and legislation.

- Lack of government commitment in financing to meet the objectives of mental health policy, particularly at the regional and district levels.

- Mental illness is not currently covered by health insurance which may impede access to treatment for the most impoverished. This means that patients have to bear the cost of treatment when they are treated outside of mental health services or if psychotropic drugs are unavailable within public health services.

- Increased demand on mental health services will lead to the need for more psychotropic medication. The cost of providing optimal treatment with new psychiatric drugs may be prohibitive.

- Rising rates of drug abuse, particularly cannabis, with resulting mental health problems may put a further strain on existing resources

5.2 Steps Needed to be Taken to Strengthen the Mental Health System

Some suggested steps to be taken to strengthen the mental health system are:

- Pass the new mental health bill, and provide the necessary resources and training for its implementation.

- Improve existing information systems for collating data on mental health, and monitoring and evaluation of services, and actively use this information for the purposes of policy and advocacy at all levels.

- Promote mental health in the development agenda to address the links between poverty and mental health

- Increase the commitment to de-centralisation through opening psychiatric units in the remaining regional hospitals. Provide outreach from the regional hospitals to support mental health at the district level.

o Develop rehabilitation within mental health services, such as half-way houses or vocational rehabilitation, in order to facilitate the social integration of people with mental illness and prevent relapse.

o Draw on lessons from anti-stigma campaigns in HIV/AIDS and disability in order to raise public awareness of mental health and tackle stigma.

o Integrate mental health into existing structures for primary care provision and public health education and case detection. Train all health workers in mental health, including all workers in primary care.

o Provide a comprehensive training programme for mental health professionals to update their skills so as to continue to provide best practice in mental health care.

o Develop retention strategies for mental health staff to address the attrition of mental health workers.

o Develop new mental health policy in line with draft mental health bill. This should be built on extensive consultation with all stakeholders.

o Promote mental health policy in the context of other relevant policy, and increase collaboration with other relevant sectors in the treatment of the mentally ill.

o Provide training for those whose work brings them into contact with the mental health problems, such as the police, teachers and social workers.

o Develop information systems for collating data on mental health, and monitoring and evaluation of services.

o Disseminate mental health policy to all levels within the health service, as well as other relevant sectors, and provide training and education to those responsible for policy implementation.

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7. Appendices

7.1 Appendix 1: Glossary of Service Definitions from WHO-AIMS

Bed: A bed that is continuously available for use by people with mental disorders for round the clock (day and night) care.

Community-based facility: A mental health facility outside of a *mental hospital*.

Community-based psychiatric inpatient unit: A psychiatric unit that provides inpatient care for the management of mental disorders within a *community-based facility*. These units are usually located within general hospitals, they provide care to *users* with acute problems, and the period of stay is usually short (weeks to months).

> **Includes:** Both public and private non-profit and for-profit facilities; *community-based psychiatric inpatient units* for children and adolescents only; *community-based psychiatric inpatient units* for other specific groups (e.g. elderly).
>
> **Excludes**: *Mental hospitals*; *community residential facilities*; facilities that treat only people with alcohol and substance abuse disorder or mental retardation.

Community residential facility: A non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders. Usually these facilities serve *users* with relatively stable mental disorders not requiring intensive medical interventions.

> **Includes:** Supervised housing; un-staffed group homes; group homes with some residential or visiting staff; hostels with day staff; hostels with day and night staff; hostels and homes with 24-hour nursing staff; halfway houses; therapeutic communities. Both public and private nonprofit and for-profit facilities are included. *Community residential facilities for children and adolescents only* and *community residential facilities* for other specifics groups (e.g. elderly) are also included.
>
> **Excludes:** Facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or mental retardation; residential facilities in *mental hospitals*; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind (e.g. nursing homes and rest homes for elderly people, institutions treating mainly neurological disorders, or physical disability problems).

Community residential facility for children and adolescents only: A facility that meets the definition for *community residential facility* and exclusively serves children or adolescents.

> **Excludes:** Facilities for children with social problems (e.g. orphans, children from disrupted families) but without necessarily a mental disorder.

Complementary/alternative/traditional practitioner: A practitioner who primarily practices traditional or complementary/alternative medicine rather than allopathic/modern medicine.

Forensic inpatient unit: An inpatient unit that is exclusively maintained for the evaluation or treatment of people with mental disorders who are involved

with the criminal justice system. These units can be located in *mental hospitals,* general hospitals, or elsewhere.

Human rights protection of users/patients: Action related to the following issues to ensure the protection of *users*' human rights: least restrictive care, informed consent to treatment, confidentiality, avoidance of restraint and seclusion when possible, voluntary and involuntary admission and treatment procedures, discharge procedures, complaints and appeals processes, protection from abuse by staff, and protection of *user* property.

Medical doctor: A health professional with a degree in modern medicine who is authorized/licensed to practice medicine under the rules of the country.

Mental health day treatment facility: A facility that typically provides care for *users* during the day. The facilities are generally: (1) available to groups of *users* at the same time (rather than delivering services to individuals one at a time), (2) expect *users* to stay at the facilities beyond the periods during which they have face-to-face contact with staff (i.e. the service is not simply based on *users* coming for appointments with staff and then leaving immediately after the appointment) and (3) involve attendances that last half or one full day.

  Includes: day centres; day care centres; sheltered workshops; club houses; drop-in centres; employment/rehabilitation workshops; social firms. Both public and private non-profit and for-profit facilities are included. *Mental health day treatment facilities for children and adolescents only* and *mental health day treatment facilities* for other specifics groups (e.g. elderly) are also included.

  Excludes: Facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind; day treatment facilities for inpatients are excluded.

Mental health day treatment facility for children and adolescents only: A facility that meets the definition for *mental health day treatment facility* and exclusively serves children or adolescents.

Mental health legislation: Legal provisions related to mental health. These provisions typically focus on issues such as: civil and human rights protection of people with mental disorders, treatment facilities, personnel, professional training, and service structure.

Mental health outpatient facility: A facility that focuses on the management of mental disorders and the clinical and social problems related to it on an outpatient basis.

  Includes: Community mental health centres; mental health ambulatories; outpatient services for specific mental disorders or for specialized treatments; mental health outpatient departments in general hospitals; mental health policlinics; specialized NGO clinics that have mental health staff and provide mental health outpatient care (e.g. for rape survivors or homeless people). Both public and private non-profit and for-profit facilities are included. *Mental health outpatient facilities for children and adolescents only* and *mental health outpatient facilities* for other specifics groups (e.g. elderly) are also included.

  Excludes: Private practice; facilities that treat only people with alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis.

Mental health outpatient facility for children and adolescents only: A facility that meets the definition for *mental health outpatient facility* and exclusively serves children or adolescents.

Mental hospital: A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental disorders. Usually these facilities are independent and standalone, although they may have some links with the rest of the health care system. The level of specialization varies considerably: in some cases only long-stay custodial services are offered, in others specialized and short-term services are also available (rehabilitation services, specialist units for children and elderly, etc.)

  Includes: Both public and private non-profit and for-profit facilities; *mental hospitals* for children and adolescents only and *mental hospitals* for other specifics groups (e.g., elderly) are also included**.**

  Excludes: *Community-based psychiatric inpatient units*; *forensic inpatient units* and forensic hospitals. Facilities that treat only people with alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis.

Non-doctor/non-nurse primary health care worker: A *primary health care clinic* staff member who provides basic health services and links with other aspects of the health care system. These staff members include medical assistants, aide-level workers, multi-purpose health workers, health assistants, community health workers, among others. The training and functions of these workers vary across countries, but are usually less than those for doctors and *nurses*. Doctors, *nurses* and other health professionals may supervise their work.

Non-physician based primary health care clinic: A *primary health care clinic* without a *primary health care doctor* as part of their regular staff.

Number of admissions: The *number of admissions* in one year is the sum of all admissions to the facility within that year. In WHO-AIMS, this number is a duplicated count. In other words, if one user is admitted twice, it is counted as two admissions.

Number of patients treated in a *mental hospital:* (a) the *number of patients* in the *mental hospital* at the beginning of the year plus (b) the *number of admissions* during the year.

Number of *users* treated in a c*ommunity residential facility*: (a) the number of *users* in the facility at the beginning of the year plus (b) the *number of admissions* to the facility during the year.

Number of *users* treated through a *mental health day treatment facility*: The number of *users* with at least one attendance for treatment at the facility within the year.

Number of *users* treated in a *mental health outpatient facility*: The number of *users* with at least one outpatient contact with the facility. A contact refers to a mental health intervention provided by a staff member of a *mental health outpatient facility*, whether the intervention occurs within the facility or elsewhere.

Nurse: A health professional having completed a formal training in nursing at a recognized, university level school for a diploma or degree in nursing.

Occupational therapist: A health professional having completed a formal training in occupational therapy at a recognized, university-level school for a diploma or degree in occupational therapy.

Other health or mental health worker: A health or mental health worker that possesses some training in health care or mental health care but does not fit into any of the defined professional categories (e.g. *medical doctors*, *nurses*, *psychologists*, *social workers*, *occupational therapists*).

  Includes: *Non-doctor/non-nurse primary care workers*, professional and paraprofessional psychosocial counsellors, special mental health educators, and auxiliary staff

  Excludes: This group does not include general staff for support services within health or mental health care settings (e.g. cooking, cleaning, security).

Other residential facility: A residential facility that houses people with mental disorders but does not meet the definition for *community residential facility* or any other mental health facility defined for this instrument (*community-based psychiatric inpatient unit, community residential facility, forensic inpatient unit, mental hospital*).

  Includes: Residential facilities specifically for people with mental retardation, for people with substance abuse problems, or for people with dementia. Included are also residential facilities that formally are not mental health facilities but where, nevertheless, the majority of the people residing in the facilities have diagnosable mental disorders.

Physician-based primary health care clinic: A *primary health care clinic* with *primary health care doctors* as part of their regular staff.

Primary health care clinic: A clinic that often offers the first point of entry into the health care system. *Primary health care clinics* usually provide the initial assessment and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to facilities with staff with a

higher level of training.

Primary health care doctor: A general practitioner, family doctor, or other non-specialized medical doctor working in a *primary health care clinic*.

Primary health care nurse: A nurse working in a *primary health care clinic*.

Psychiatrist: A *medical doctor* who has had at least two years of post-graduate training in psychiatry at a recognized teaching institution. This period may include training in any sub-specialty of psychiatry.

Psychologist: A professional having completed a formal training in psychology at a recognized, university-level school for a diploma or degree in psychology. WHO-AIMS asks for information only on *psychologists* working in mental health care.

Psychosocial intervention: An intervention using primarily psychological or social methods for the treatment and/or rehabilitation of a mental disorder or substantial reduction of psychosocial distress.

  Includes: psychotherapy; counselling; activities with families; psycho-educational treatments; the provision of social support; rehabilitation activities (e.g. leisure and socializing activities, interpersonal and social skills training, occupational activities, vocational training, sheltered employment activities).

  Excludes: Do not include intake interviews; assessment; follow-up psychopharmacology appointments as psychosocial interventions.

Public education and awareness campaign: An organized, coordinated effort to educate the public and raise their awareness about issues related to mental health using a variety of tools (e.g. media, brochures, face-to-face initiatives).

Excludes: Commercial advertisements (e.g. by pharmaceutical companies); advertisements for research studies.

Refresher training in psychiatry/mental health: The provision of essential knowledge and skills in the identification, treatment, and referral of people with mental disorders. *Refresher training* occurs after university (or vocational school) degree training. Eight hours of training is equivalent to one day of training.

Includes: In-service training.

Excludes: Training exclusively in neurology.

Social worker: A professional having completed a formal training in social work at a recognized, university-level school for a diploma or degree in social work. WHO-AIMS asks for information only on *social workers* working in mental health care.

User/Consumer/Patient: A person receiving mental health care. These terms are used in different places and by different groups of practitioners and people with mental disorders, and are used synonymously in WHO-AIMS.

7.2 Appendix 2: WHO Mental Health Policy, Plan and Legislation Checklists

7.2.1 WHO Checklist on Mental Health Legislation

WHO Checklist on Mental Health Legislation

This checklist has been developed collaboratively by Mental Health Policy and Service Development team of the World Health Organization, Headquarters and Professor Melvyn Freeman, WHO faculty member for legislation, with contributions from Dr Soumitra Pathare and Dr Helen Watchirs, also WHO faculty for legislation . It has been derived from the WHO manual on Mental Health Legislation, Mental Health Policy and Service Development Team, Department of Mental Health and Substance Dependence, World Health Organization, 2003.

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Introduction and how to use this Checklist

This Checklist is a companion to the WHO Manual on Mental Health Legislation. Its objectives are to a) assist countries in reviewing the comprehensiveness and adequacy of existing mental health legislation and b) help them in the process of drafting new law. By using this instrument countries can assess whether key components are included in legislation and ensure that the broad recommendations contained in the manual are carefully examined and considered.

A committee to work through the checklist is recommended. While an individual such as the focal point in the Ministry of Health may be able to complete the tool this has limitations. Firstly, a single person is unlikely to have all the relevant information that a well selected team would. Secondly, different individuals or representatives of different groups are likely to have differing views on various issues. An evaluation committee which allows critical debate to take place and for consensus to be developed is invaluable. While countries must decide the composition of the committee it is advisable to include a legal practitioner familiar with various country laws, the governmental mental health focal point, representatives of consumer and family groups, representatives of mental health professionals, non-governmental organisations and other government departments. It is recommended that the process be led and mediated by an independent human rights and/or legal expert.

This tool should generally not be utilised without thoroughly working through the manual itself. A number of important items included in this tool are explained in the manual and the rationale and different options for legislation are discussed. The manual emphasises that countries should make their own decisions around various alternatives and ways of drafting legislation as well as around a number of content issues. The format of this Checklist allows for such flexibility and aims to encourage internal debate, thus permitting countries to make decisions based on their own unique situations.

The tool covers issues from a broad perspective and many of the provisions will need to be fleshed out/elaborated upon with respect to details and country specifications. Moreover, not all provisions will be equally relevant to all countries due to different social, economic, cultural and political factors. For example not all countries will choose to have community treatment orders; not all countries have provision for "non-protesting patients"; many countries do not have the death penalty and, in most countries, the use of sterilisation on people with mental disorders will not be relevant. However, while each country in their evaluative process may determine that a particular provision is not relevant, this determination should be made as a part of the Checklist exercise. All provisions in the checklist should be considered and discussed carefully before it is decided that one or more provision is not relevant to a country's particular context.

The manual points out that countries may have laws which affect mental health in a single or in numerous different legislations, for example general health, employment, housing, discrimination and criminal justice laws, among others. Moreover some countries utilise regulations, orders and other mechanisms to complement an Act. When conducting this audit it is therefore essential to collect and collate all legal

provisions relating to mental health and to make decisions based on comprehensive information.

For each component included there are three options to be decided upon, a) has the issue been adequately covered in the legislation b) has it been covered, but not fully and comprehensively and c) has it not been covered at all. If the response is either (b) or (c) the committee conducting the assessment must decide the feasibility and local relevance of inclusion of the issue – leading to the drafting of locally appropriate legislation.

This Checklist does not cover each and every issue that could or should be included in legislation. This does not mean that other items are unimportant and that countries should not pursue them, however for the sake of simplicity and easy use the scope of this Checklist has been limited.

The manual is very clear that drawing up or changing mental health legislation is a "process". Establishing what needs to be included in the legislation is an important element of this process and this Checklist tool a useful aid to achieving this goal. Nonetheless, the objective of drafting a law which is implementable in a country must never be separated from the "content" and must always be a central consideration.

WHO Checklist on Mental Health Legislation[1]

Legislative issue	Extent to which covered in legislation (Tick one) a) Adequately covered b) Covered to some extent c) Not covered at all	If (b) explain: • Why it is not adequately covered • **What is missing or problematic about the existing provision** **If (c) explain why it is not covered in current legislation** (Additional information may be added to new sheets of paper if required)	If (b) or (c) explain how/whether it is to be included in new legislation (Additional information may be added to new sheets of paper if required)

A. Preamble and objectives
 	
1) Does the legislation have a preamble which emphasizes:-
   a) the human rights of people with mental disorders
 	
   b) the importance of accessible mental health services for all
 	
2) Does the legislation outline that the purpose and objectives to be achieved include:-
	a)
	b)
	c) √
	
	a)
	b)
	c) √
		a) The inclusion of a human rights component in mental health legislation would help address historical and present injustices carried out against people with mental disorders. Ensuring equity between mental and physical health remains a major problem in most African countries. Highlighting the human rights of people with mental disorders can help address this problem. The human rights aspects of mental health law can be augmented by using international standards and other legal instruments.
		
		b) Because the legislation focuses almost solely on care and treatment in psychiatric hospitals and psychiatric units, there is no emphasis on accessible mental health services in the community. The closest the statute comes to discussing broader access to mental health services is in Part V, Para. 28, which provides that the commissioner *may* provide for aftercare services and rehabilitation centres.
		
		a) The statute does not contain any provisions requiring non-discrimination against people with mental disorders.
		
		b) The statute does not explicitly provide for the promotion and protection of the rights of people with mental disorders. However, certain provisions implicitly promote rights by limiting the exercise of the state commitment power, albeit imperfectly. Other	

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[1] **NOTE: "New" scores (marked with a highlight) reflect the following. (a) issue addressed adequately, (b) issue well addressed, but not perfectly, (c) issue not addressed, or so badly addressed that, effectively, it is as if it was not addressed**

a) non-discrimination against people with mental disorders b) promotion and protection of the rights of people with mental disorders c) improved access to mental health services d) a community based approach	*a)* *b)* *c)* √ *a)* *b)* *c)* √ *a)* *b)* *c)* √ *a)* *b)* *c)* √	provisions, such as those in Part I, Para. 2, regarding the duty of the chief administrator to keep patients clean, adequately nourished, and adequately clothed, could entail protection of patient rights, though there does not appear to be any way for patients to enforce these rights. There is no mention of the rights to confidentiality of information, access to information, communication, autonomy or privacy. Nor does the statute address the rights of persons outside of the psychiatric hospital, such as civil and political rights. These rights are particularly important because of the stigma associated with mental illness. **c)** The statute does not address improved access to mental health services at all. Access to mental health care services can be improved by decentralization and integration of mental health services in general health care. The law should indicate that people with mental disorders have the right to receive treatment under the same conditions as individuals with general medical conditions. **d)** The statute does not emphasize a community-based approach to providing mental health services. The focus of the law is almost exclusively on institutional care, other than the provision in Part V, Para. 28 permitting (but not requiring) the commissioner to provide for aftercare services and rehabilitation centres. It would be useful to have an objective that addressed service organization and reform in the law.	

B. Definitions 1) Is there a clear definition of mental disorder/mental illness/mental disability/mental incapacity/unsoundness of mind? 2) Is it evident from the legislation why the particular term (above) has been chosen? 3) Is the legislation clear on whether or	*a)* *b)* *c)* √ *a)* *b)* *c)* √ *a)*	**1)** The statute does not contain a definition of mental disorder/mental illness/ mental disability/mental incapacity and unsoundness of mind. The statute consistently uses the term "mental illness" but does not indicate why this term is preferred over "mental disorder" or the other terms. Part V, Para. 25 states that "*The provisions of this Decree shall apply to persons suffering or believed to be suffering from any degree of mental disorder, psychopathic disorder, arrested or incomplete development of mind, mental subnormality or any other disorder or disability of the mind, howsoever, called, as they apply to persons suffering or believed to be suffering from mental illness.*" The absence of clear (or any) definitions of these terms in the statute presents opportunities for abuse. **2)** It is not evident from the legislation why the term "mental illness" has been used. While that term is generally considered to be narrower than the term "mental disorder," and is thus preferred when dealing with issues concerning eligibility for civil commitment, the broader "mental disorder" is recommended when focusing on issues related to the rights of patients. **3)** Part V, Para. 25, states that persons with arrested or incomplete development of the mind or mental sub-normality are included in the statute. Presumably, these terms relate to people with mental retardation or developmental delay, though the substantive provisions of the statute do not address the needs (or rights) of this population. People with	

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not mental retardation, personality disorders and substance abuse are being covered in the legislation?	*b)* √ *c)*	"psychopathic disorder" are also included in the law, which presumably includes people with personality disorders. However, the statute makes no explicit mention of substance abuse; it is unclear whether Para. 25's use of the phrase "*any other disorder or disability of the mind*" includes substance abuse, as that term can be associated with an alteration of cognition and general mental functioning. Again, though, there are no specific substantive provisions that would address the peculiar needs of substance abusers. The statute needs to be clear about such issues.	
4) Are all key terms in the legislation clearly defined?	*a)* *b)* *c)* √	**4**) The statute defines few terms: the only explicit definitions are of the terms "chief administrator" and "Commissioner" in Part V, Para. 30. Key terms such as "dangerous to self or others" (Part IV, Para. 17), "care and treatment adequate to his case," "practioner experienced in psychiatry," "patient," and so on (Part I, Para. 2 (b)) are not defined in the Decree.	
5) Are all "interpretable" terms (that is, terms that may have several possible interpretations or meanings or may be ambiguous in terms of their meaning) in the legislation defined?	*a)* *b)* *c)* √	**5**) The statute does not provide clear definitions of "interpretable terms." For example, under Part II, Para. 7 (2), the chief administrator shall discharge a voluntary patient "*when he is satisfied that the patient has recovered from his mental illness to justify discharge.*" This definition is circular at best. Other examples include Part II, Para. 8 (5) (magistrate must be satisfied there is "*good reason to believe*" the person requires temporary treatment of up to six months) and Part II, Para. 9 (1) (chief administrator can apply for prolonged treatment of person with mental illness when he "*is of the opinion that, by reason of the severity or nature of the mental illness it is necessary for the welfare of such person or for the public safety*").	
	a) *b)* *c)*	Although there does not generally seem to be a confusion of terms, as not all key terms are defined it is difficult to know what is meant by given terms. For instance, the law generally uses the term "mental illness" but then in s. 17 (a)states "the patient is not then suffering from <u>mental illness</u> or any other <u>mental disorder</u>", without otherwise explaining how the terms relate to each other.	

C. Access to mental health care			
1) Does the legislation make provision for the financing of mental health services?	*a)* *b)* *c)* √	**1**) The legislation does not provide for the financing of mental health services. In most African countries the mental health budget is less than 1% of the health budget, while in other countries a mental health budget appears not to exist at all (WHO Atlas 2001). In situations where it is not possible to specify financing of mental health services, clauses within the legislation can help to direct existing funding, for example, by emphasizing that people with mental disorders be treated on an equitable basis with people with physical health problems, or by emphasizing community-based services over institutional care. Such statements can prompt the authorities to allocate resources to appropriate mental health services.	
2) Does the legislation state that mental health services should be provided on an equal basis with physical health care?	*a)* *b)* *c)* √	**2**) The statute does not require or suggest that mental health services be provided on an equal basis with physical health services. An emphasis on equity with physical health will help to improve access and availability of mental health services.	
3) Does the legislation ensure allocation of resources to underserved populations	*a)* *b)*	**3**) The Decree does not address allocation of resources to under-served populations. Because most of Africa has a large rural population that is often marginalized, focus on these vulnerable and disadvantaged groups is critical to improving access to and availability of services. Legislation can establish criteria for establishing the needs of communities. The statute also does not mention culturally appropriate services. Culture plays an	

and that these services should be culturally appropriate?	c) √	important role in most African communities and cultural values may need to be incorporated when dealing with certain issues such as confidentiality.	
4) Does the legislation promote mental health within primary health care?	a) b) c) √	**4)** The legislation does not promote mental health within primary health care. The statute is focused almost exclusively on care and treatment in tertiary institutions. By emphasizing decentralization, mental health would be put on an equal footing with general health benefits. Most developing countries have comprehensive primary care services that are aimed at promoting physical health care with a focus on conditions such as malaria, TB, HIV, and many others. Therefore, by emphasizing that mental health services be delivered through general health care services it is possible to increase the access of under-served populations to mental health services.	
5) Does the legislation promote access to psychotropic drugs?	a) b) c) √	**5)** The legislation does not promote access to psychotropic drugs. Because mental health services in Africa are often neglected, legislation can address this anomaly by stating that medication for mental disorders be as available and accessible as medication for other medical conditions.	
6) Does the legislation promote a psycho-social rehabilitative approach?	a) b) √ c)	**6)** The legislation does provide in Part V, Para. 28, that "*the commissioner may make such provision for after-care services (including supervision) and rehabilitation centres for discharged patients as he may consider necessary or expedient. . . "* However, this provision is not mandatory (unlike the provision in Para. 22 of the 1990 proposal, which appears to be). There is a need for a clearly defined psycho-social rehabilitation procedure in the legislation with emphasis on community and family participation.	
7) Does the legislation promote access to health insurance for people with mental disorders in the private and public health sector?	a) b) c) √	**7)** There is no mention of access to health insurance for people with mental disorders. Legislation may contain provisions to prevent discrimination against people with mental disorders in their efforts to obtain health insurance coverage.	
8) Does the legislation promote community care and deinstitutionalisation?		**8)** The legislation does not promote community-based care and de-institutionalization. Statutory language can provide that, if at all possible, patients should be treated in their communities and as voluntary patients, unless there are clearly-articulated reasons why hospital-based care is required. By emphasizing community-based care, services are more likely to be incorporated into the general health care system, thus resulting in better access and availability of care for people with mental disorders.	

D. Rights of users of mental health services 1) Are the rights to respect, dignity and to be treated in a humane way included	a) b) √	**1)** The statute does not fully address patients' rights to respect and dignity, and the right to be treated in a humane way. However, Part I, Para. 2, provides that it is the duty of the chief administrator of each hospital to ensure that every patient is kept b) "*adequately nourished and receives care and treatment adequate to his case; c). . . adequately clothed, and d) that every complaint is promptly investigated and*	

in the legislation?	*c)*	*appropriate action taken.”* Arguably, Part V, Para. 22, protects personal dignity by permitting a magistrate to authorize police intervention when a person who appears to be suffering from mental illness is subjected to ill-treatment or neglect.
2) Is the right to patient confidentiality regarding information about themselves, their illness and treatment included?	*a)* *b)* *c)* √	The use of the broad terms *adequate* and *appropriate* above may be problematic, especially against a background of already existing injustices and misconceptions surrounding mental health. The rights of persons with mental disorders need to be clearly stated.
a) Are there sanctions and penalties for people who contravene patient confidentiality?	*a)* *b)* *c)* √	**2)** The statute has no provisions for protecting patient confidentiality regarding information about themselves, their illness and treatment is not included. Therefore, the statute neither provides for sanctions against contravention of this right nor allows for exceptional circumstances when confidentiality may be breached.
b) Does the legislation lay down exceptional circumstances when confidentiality may be legally breached?	*a)* *b)* *c)* √	Because of widespread violations of the rights of people with mental disorders, protecting information about their mental health is critical. In many countries, information concerning patients has been used to deny them such basic rights such as the right to vote, the right to work, the right to live in the community, the right to communicate, and other civil and political rights.
c) Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to release information?	*a)* *b)* *c)*	While protecting the rights of patients, legislation should also determine the special cases under which confidentiality may be breached appropriately. Exceptional cases such as life-threatening emergencies or substantial likelihood of imminent harm to others may be legitimate grounds for breaching confidentiality, but it is important that any such exceptions be narrowly drawn.
		Issues concerning the rights of families to confidential information regarding the patient need to be discussed and worked through. See below.Section D - Rights of families or other carers.
3) Does the legislation provide patients free and full access to information about themselves (including access to their clinical records?	*a)* *b)*	**3)** The legislation does not provide patients free and full access to information about themselves, nor does it set out the circumstances in which it would be appropriate to deny such access.
a)Are circumstances in which such access can be denied outlined?	*c)* √	As a matter of equity, people with mental disorders should have as free

b) Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to withhold information?	a) b) c) √ a) b) c)	and full access to information concerning their health as people with physical conditions do. Exceptions to access may be legitimate, but must again be narrowly tailored. Legislation can outline the procedures for patients to exercise their right to gain access to information, and the circumstances where denial of access is appropriate.	
4) Does the law specify the right to be protected from cruel, inhuman and degrading treatment?		**4)** The statute law does not provide for the right to be protected from cruel, inhuman and degrading treatment. Under Part I, Para. 2, the visiting committee can inquire into patient complaints, which presumably could include claims regarding such treatment, but in the area of patient rights the statute should be more specific. Principle 13, MI Principles, has a clear outline of these basic rights.	
5) Does the legislation set out the minimal conditions to be maintained in mental health facilities for a safe, therapeutic and hygienic environment?	a) b) c) √	**5)** The statute does set out in a general way the requirement that mental health facilities be maintained in a safe, therapeutic and hygienic environment. Part I, Para. 2(a) states "*that every part of the hospital, including wards, kitchens (sic) washing facilities and toilets, are at all times kept in a clean and sanitary condition.*" Para. 2(b) provides in part that every patient receive *"care and treatment adequate to his case."* However, these provisions do not set out the specific conditions that constitute a safe, therapeutic and humane environment. Moreover, while the language clearly addresses the requirement of a hygienic environment, there is no particular emphasis on safety, and the therapeutic requirement must be gleaned from the vague language of *"care and treatment adequate to his case."*	
6) Does the law insist on privacy of people with mental disorders? a) Is the law clear on minimal levels of privacy to be respected?	a) b) √ c)	**6)** The statute does not insist on recognizing the privacy of patients with mental disorders, except to the extent that it provides for female patients and children under the age of sixteen to be accommodated separately. *See* Part V, Paras. 26 (1), (2), discussed below. In resource-poor settings, where private rooms for every patient may not be feasible, legislation can still require that patients admitted in mental health institutions be treated in the same manner as those admitted to general medical wards. **a)** The statute is not clear on the minimal levels of privacy to be respected. The law can be precise in defining the conditions of privacy in the institution, for example, by stipulating the minimum living space available for each patient, the maximum number of beds in a ward, and the need for patients to have a private area where they can store their personal items.	
7) Does the legislation outlaw forced or inadequately remunerated labour within mental health institutions?	a) b) c) √		

8) Does the law make provision for:
 	
   Educational activities
   Vocational training
   Leisure and recreational activities
   Religious or cultural needs
	a)
	b)
	c) √
	
	a)		

of people with mental disorders?	*b)* *c)* √	**7)** The statute does not address, and hence does not make illegal, forced or inadequately remunerated patient labor. Labor that is part of an occupational therapy program, or that is legitimately assigned for therapeutic purposes, is not equivalent to proscribed patient labor. The law may state that in circumstances where patients consent (without coercion) to perform a specific task, they should be remunerated accordingly.	
9) Are health authorities compelled by the law to inform patients of their rights? 10) Does legislation ensure that users of mental health services are involved in mental health policy and legislation development and service planning?	*a)* *b)* *c)* √		
	a) *b)* *c)* √ *a)* *b)* *c)* √	**8)** The law does not make provisions for educational, vocational training, leisure and recreational activities, and religious or cultural needs of people with mental disorders. If the environment within a mental health facility is intended to be as close as possible to the patient's home environment, then the patient's needs should be viewed in a holistic manner. These basic rights are enshrined in the MI Principles (Principle 13). **9)** Health authorities are not compelled by law (in this legislation, at least) to inform patients of their rights. Because for a variety of reasons patients are sometimes not aware of their rights, legislation should include a provision for informing patients of their rights when dealing with mental health services. This information should be made available in a simple yet comprehensive manner. The law may also stipulate that this information be made available in a language, and at a level of complexity, that the patient understands. **10)** There is no provision for users of mental health services to be involved in the development and planning of mental health services. Including such a provision in the law encourages the formation of user groups and makes their contribution to the development of the mental health service system more transparent.	
E. Rights of families or other carers 1) Are families or other primary care givers entitled under the law to information about the person with mental disorder (unless the patient	*a)* *b)* *c)* √	**1)** There is no indication in the law that families and other primary care givers are entitled to information about the person with a mental disorder. Part V, Para. 27 states that families and friends may visit the patient but there is no mention of them being entitled to information concerning the patient. Because families often carry the burden of care for people with mental disorders, legislation needs to recognize the role that they play. In most African cultures, the extended family system plays a crucial role in decision making, support and care, particularly where a member of the family is ill. Therefore, it may become necessary for certain family members to be informed of the person's situation. While family members' access to information must be balanced against the person's right to confidentiality, cultural and other traditional values may counsel more rather than less	

refuses for such information to be divulged)?		information sharing. In all circumstances potential conflicts of interest need to be examined, the views of the person with the mental disorder must be taken into account and only information relevant for the support and care of the person should be considered.	
2) Are family members or other primary care givers encouraged to be part of the treatment plan?	*a)* *b)* **c)** √	**2)** The statute has no provisions encouraging family members or other primary care givers to be part of the treatment plan. (Indeed, the statute does not provide for treatment plans at all.) There is no real emphasis on care provided for the patient after leaving the hospital. Family members often take responsibility for ensuring that the patient takes his medication, attends review clinics, and participates in other rehabilitation exercises in the community. By involving family members, the care provided outside of the hospital system may be more consistent and there is less likelihood of the family resorting to alternative treatments such as traditional medicines when they are involved and understand the treatment plan.	
3) Do families or other primary care givers have the right to appeal involuntary admission and treatment decisions.	*a)* *b)* √ **c)**	**3)** Although neither family members nor other primary care givers have an explicit right to appeal involuntary admission and treatment decisions, Part IV, Para. 16, establishing the Mental Health Review Tribunal, does provide that "*an application may be made to the Tribunal by or in respect of any person detained under this decree…(a) requesting a review of the conditions under which he is detained; or (b) requesting his discharge; or (c) requesting any other appropriate action to be taken with respect to the circumstances of his case.*" It is not clear whether this procedure is in the nature of an appeal or rather functions as a kind of habeas corpus procedure to test the legality of continued confinement. In any event, families are not singled out in this process. Moreover, issues such as the nature of the Tribunal's procedures, the time frame within which it must make a response to an application, the nature of the decisions the Tribunal can make, and its overall authority are not clear. Furthermore, reviews of involuntary status should not be limited to appeals. Reviews should be held on an automatic basis for all cases at certain set time periods.	
4) Do families or other primary care givers have the right to apply for the discharge of mentally ill offenders?	*a)* *b)* **c)** √	**4)** Families and other primary care givers do not have the right to apply for the discharge of mentally ill offenders under this statute.	
5) Does legislation ensure that family members or other carers are involved in mental health policy and legislation development and service planning?	*a)* *b)* **c)** √	**5)** The legislation does not encourage family members or other care givers to be involved in mental health policy, legislation development, and service planning.	
F. Competence, capacity and guardianship		**1)** The legislation does not make provision for the management of the affairs of people with mental disorders if they are unable to do so, with one exception: under Part II, Para. 7 (3), the chief administrator can discharge a voluntary patient who is "*incapable of expressing his intentions*" to the care of a relative or other suitable person.	
1) Does legislation make provision for the management of the affairs of people with mental disorders if they are unable to do so?	*a)* *b)* **c)** √	**2)** The statute neither defines "competence" and "capacity" nor does it use this terminology at all. The only references to lack of capacity or competence (though not stated in those terms) is the above reference to patients who are incapable of expressing their intentions and a later one, in Part V, Para. 22 (b), to people with apparent mental disorders in the community who are "*unable to care for*" themselves. "Capacity" and "competence" are useful terms for dealing with people with mental disorders because the presence of mental illness in itself does not automatically mean that the individual lacks capacity (the ability to make decisions) or competence (legal consequences of not having mental capacity). These terms are important when dealing with the judiciary, other branches of government, and civil society, and are distinct from a diagnosis of mental disorder. All persons are presumed to have capacity and be competent, even if suffering from a mental disorder, unless reliably determined otherwise.	
2) Does the law define "competence" and "capacity"	*a)* *b)* **c)** √		

3) Does the law lay down a procedure for determining a person's incapacity/incompetence with respect to issues such as treatment decisions, selection of a substitute decision maker, making financial decisions?	*a)* *b)* *c)* √	**3) through 8)** The law does not set out a procedure for determining a person's incapacity/incompetence in any area, nor does it provide for guardianship or other forms of surrogate decision making. Guardianship may become necessary in the event that a patient is unable to make important decisions and is incapable of managing his affairs. However, because guardianship takes away a person's right to make decisions (in whole or in part), it is a major limitation on one's civil rights, which should only be used after less restrictive alternatives have been exhausted and due process procedures have been followed (including notice, hearing, appeal, and periodic review).	
4) Are procedures laid down for appeals against decisions of incapacity/incompetence and for periodic reviews of decisions?	*a)* *b)* *c)* √		
5) Does the law lay down procedures for the appointment, duration, duties and responsibilities of a guardian to act on behalf of a patient?	*a)* *b)* *c)* √		
6) Does the law determine a process for establishing which areas a guardian may take decisions on behalf of a patient?	*a)* *b)* *c)* √		
7) Does the law make provision for the systematic review of the need for a guardian?	*a)* *b)* *c)* √		
8) Does the law make provision for a patient to appeal against the appointment of a guardian?	*a)* *b)* *c)* √		
G. Voluntary Admission and treatment		**1)** Part II deals with voluntary admission, however, there is no effort to promote this form of treatment over involuntary admission and treatment. The law does not emphasize that every effort should be made to avoid involuntary admission.	

1) Does the law promote voluntary admission and treatment?	a) b) √ c)	**2)** The statute does not provide for obtaining informed consent from patients before treating them. Note that the unadopted 1990 proposed statute, Part III, Paras. 11. (2), (3), would have required prior consent for treatment of voluntary patients, and substituted consent (by a relative or responsible adult) for those unable to consent.	
2) Does the law state that all voluntary patients can only be treated after obtaining informed consent?	a) b) c) √	**3)** The law does not state that people admitted as voluntary mental health users should be cared for in a way that is equitable with how people with physical health problems are treated. The law states that a voluntary patient "*may discharge himself at any time upon givingwritten notice to the chief administrator of the hospital,*" Part II, Para. 7. (1). After the giving of written notice, however (which under Part II, Para. 7. (4) must be at least 72 hours before the proposed discharge), it is presumably possible for the chief administrator to seek temporary or prolonged commitment of the person. Moreover, Part II, Para. 7. (2) states that the chief administrator "*may discharge a voluntary patient . . . where he is satisfied that the patient has recovered from his mental illness sufficiently to justify such discharge.*" It is not clear whether patients admitted for physical conditions are subjected to the same discharge hurdles. Any prevention of discharge must be on the basis of clearly set out criteria	
3) Does the law state that people admitted as voluntary mental health users should be cared for in a way that is equitable with patients with physical health problems	a) b) c) √		
4) Does voluntary admission and treatment imply the right to voluntary discharge/refusal of treatment?	a) b) c) √	**4)** Voluntary admission /treatment does not seem to imply the right to voluntary discharge/refusal of treatment. There is no provision in the law requiring that the voluntary patient be advised that under some circumstances his request for discharge can be denied.	
5) Does the law state that a voluntary patient is informed at the time of admission, that they may only be denied the right to leave if they meet the conditions for involuntary care?	a) b) c) √	**5)** The voluntary patient is not informed of the possibility of being denied discharge only if he or she meets the criteria for involuntary admission at that time.	
H. Non-protesting patients 1) Does the law make provision for patients who are incapable of making informed decisions, but who do not refuse treatment? 2) Are the conditions under which a non-	 a) b) c) √ a)	**1)** The law does not make provision for patients who are incapable of making informed decisions, but do not refuse treatment, so-called non-protesting patients. Although Part II, Para. 5. (1) states that an application for voluntary admission can be made on behalf of the patient by a "*responsible person,*" it is not clear under which circumstances this procedure may be used (for example, whether it is only available when the person does not have the capacity to make the decision seeking treatment on his or her own). Therefore, it is not clear whether this provision applies to non-protesting patients. With respect to *release* from the hospital, Part II, Para. 7. (3) provides that the chief administrator may discharge to a relative or other suitable person "*a voluntary patient. . . incapable of expressing his intentions.*" The issue of non-protesting patients refers primarily to patients who do not meet the criteria for either voluntary or involuntary treatment, for example, patients with mental retardation.	

protesting patient may be admitted and treated laid out?	*b)* *c)* √	In such cases, the need for hospitalization alone can be sufficient to warrant such an admission. Although the criteria for admission as a non-protesting patient are generally considered to be not as rigid as for involuntary patients, non-protesting patients should nevertheless qualify for automatic review procedures.	
3) Does the law state that if a user admitted/treated under this provision objects to their admission/treatment they must be discharged/treatment stopped unless the criteria for involuntary admission are met.	*a)* *b)* *c)* √	**2), 3)** The statute does not set out any conditions for the admission or treatment of non-protesting patients. The inclusion of such language in the law would be helpful because the statute does include persons who could potentially meet this criterion in Part V, Para. 25 (*"persons suffering from. . . arrested or incomplete development of mind"*). Presumably, the requirement in Part II, Para. 6. (1) permitting admission of a voluntary patient *"if adequate facilities for his treatment are available"* provides some protection against admitting a person with mental retardation to a facility that did not have appropriate habilitative services. However, the provisions for temporary (Part III, Para. 8) and prolonged commitment (Part III, Para. 9) do not have such a limitation, other than that the purpose of the temporary commitment, at least, is to place the person under "care, observation and treatment."	
I. Involuntary admission (when separate from treatment) and involuntary treatment (where admission and treatment are combined) 1) Does the law state that involuntary admission may only be allowed if:- a) there is evidence of mental disorder of specified severity b) there is likelihood of harm to self or others and/or deterioration in patient's	 *a)* *b)* *c)* √ *a)* *b)*	**1a)** The statute does not limit involuntary admission to people who have a mental disorder of specified severity. Part III, Para. 8. (1), provides for temporary commitment (for up to six months) of individuals where *"it is expedient for the welfare of any person believed to be suffering from mental illness, or for public safety, that such a person should be placed under care, observation and treatment in a psychiatric hospital."* Pursuant to Part III, Para. 9. (1), which provides for prolonged treatment (for up to 18 months, a period that can be renewed), a person with a mental disorder may be committed where *"by reason of the severity or nature of the mental illness it is necessary for the welfare of such person or for the public safety that he should be placed under prolonged treatment. . ."* These standards are vague and conclusory, though it is perhaps implicit that prolonged treatment should only be used when the mental illness is reasonably severe. Having a mental illness in itself should not be used to justify involuntary admission and treatment. The law needs to be specific regarding the reasons for involuntary admission. Both Part III, Para. 8. (2)(a) and Part III, Para. 9. (3)(a) require the admitting doctor to *"specify in full details the reason why he considers that person to be a proper subject for* [*care, observation and treatment*] [or] *prolonged treatment."* However, the statute provides no substantive guidance on what those reasons should be. Because the reasons for admission can vary from one doctor to another, there is a need for consistency in the law. Therefore, it is necessary to stipulate specifically the reasons that can lead to involuntary admission, such as: the presence of a diagnosable mental disorder coupled with i) dangerousness to self; ii) dangerousness to others; or iii) grave disability, such that there is a high risk of serious deterioration in his or her mental condition. Admisison criteria also needs to include reference to therapeutic purpose of the admission. See below.	

condition if treatment is not given	*c)* √	**1b)** While concern for public safety can be a basis for both temporary and prolonged commitment, there are no provisions establishing that there must be any likelihood of harm to self or others and/or deterioration in the patient's condition in the absence of treatment. In many societies, people with mental disorders are perceived to be threats to the public safety simply because they suffer from a mental disorder. Yet people with mental disorders are no more dangerous than the general population (and for some mental disorders may be considerably less so). Within the category of potential harm to self or others, there is no requirement that there be any recent overt act demonstrating such dangerousness.
c) admission requires a therapeutic purpose	*a)* *b)* *c)* √	**1c)** The statute does not require that admission serve a therapeutic purpose. The requirement that the person be *"placed under care, observation and treatment,"* would still permit admission for custodial or other non-therapeutic purposes. If involuntary admission does not ultimately lead to an improvement in the person's clinical conditions, the rationale for admission is called into question.
2) Does the law state that two accredited mental health care practitioners must certify that the criteria for involuntary admission have been met?	*a)* *b)* √ *c)*	**2)** For temporary commitments, the statute provides, Part III, Par. 8. (1), that there must be two medical recommendations for admission, one of which must be from a practitioner experienced in psychiatry. Prolonged treatment under Part III, Par. 9. (1), (3) requires only one medical recommendation, though it must be from a practitioner experienced in psychiatry. There is no definition of "experienced in psychiatry" and the statute is silent on accreditation of either of these two medical practitioners.
3) Does the law insist on accreditation of a facility to admit involuntary patients?	*a)* *b)* √ *c)*	**3)** While the statute permits the Commissioner to establish psychiatric hospitals, Part I, Para. 1. (1), and requires him to ensure they meet certain standards of cleanliness, patient clothing, patient nourishment, receipt of adequate care and treatment, and investigation of complaints, it does not establish any requirement that the hospital be accredited as such.
4) Is the principle of the least restrictive environment applied to involuntary admissions?	*a)* *b)* *c)* √	**4)** The principle of the least restrictive environment is not applied to involuntary admissions.
5) Does the law make provision for an independent authority (e.g. Review Body or tribunal) to authorise all involuntary admissions?	*a)* √ *b)* *c)*	**5)** The statute provides that a magistrate must authorize all temporary commitments of up to 6 months (Part III, Para. 8. (4)) and all prolonged commitments of up to 18 months (Part III, Para. 9. (7)). In addition, while the Mental Health Review Tribunal established in Part IV does not "authorize all involuntary admissions," it does have authority, if requested, to review the conditions of detention or to grant the person's discharge, pursuant to Part IV, Para. 16.
6) Are speedy timeframes laid down within which the independent authority must make a decision?	*a)* *b)* *c)* √	**6)** There are no time frames (speedy or otherwise) established for either the magistrate to make the initial commitment decision nor for the Mental Health Review Tribunal to act. Given the lengthy time of "temporary commitment" (6 months) and "prolonged commitment" (18 months, renewable), the absence of time frames is especially problematic.
7) Does the law insist that patients, families and legal representatives be	*a)*	**7)** The law does not provide that patients' families and legal representatives be informed of the reasons for admission, and their rights with respect to appeal. Although it might be possible through the Mental Health Review Tribunal to apply for a review of admission, the statute does not require that the patient and his legal

informed of the reasons for admission and their rights with respect to appeals? 8) Does the law provide a right to appeal an involuntary admission? 9) Are there time-bound periodic reviews of involuntary (and long term 'voluntary') admission cases in the legislation? 10) Does the law specify that patients must be discharged from involuntary admission as soon as they no longer fulfil the criteria for involuntary admission?	*b)* *c)* √ *a)* *b)* √ *c)* *a)* *b)* *c)* √ *a)* *b)* *c)* √	representatives be informed of this right upon admission. **8)** Again, there is no specific right to appeal, though review of the initial involuntary commitment may be possible through the Mental Health Review Tribunal. It is not clear what procedures the Tribunal applies to requests that people submit to it. **9)** There are no time-bound periodic reviews of involuntary admissions. Temporary admissions are limited to 6 months, and prolonged admissions to 18 months, but the latter are renewable. (Note: in the 1990 proposed statute, the 18-month commitment would not have been renewable.) It is not clear who bears the burden of persuasion on renewals of prolonged commitment. **10)** The statute does not provide for discharge from involuntary admission as soon as the patient no longer meets the criteria for involuntary admission. While the chief administrator may discharge a voluntary patient *"where he is satisfied that the patient has recovered from his mental illness sufficiently to justify such discharge,"* Part II, Para. 7. (2), there is no comparable provision in the involuntary commitment sections (and even in the voluntary context, such discharge is not mandatory and is based on vague criteria.) The patient or interested person on his behalf can apply to the Mental Health Review Tribunal for discharge pursuant to Part III, Para. 16. (b), but the law is silent on what the standards for discharge are. A provision requiring discharge as soon as the person no longer meets admission criteria is important to ensure that patients do not experience the "massive curtailment of liberty" entailed in involuntary commitment any longer than is necessary.	

J. Involuntary treatment (when separated from involuntary admission)
 	
1) Does the law set out the criteria that must be met for involuntary treatment including:
    • Patient suffers from a mental disorder
 	
    • Patient lacks capacity to make informed treatment decisions
	
	a)
	b)
	c) √
	
	a)
	b)
		1)-7) Because the statute does not separate out involuntary treatment from involuntary admission (and, indeed, does not even address the issue of involuntary treatment at all), we do not separately analyze the issues in this section. Suffice it to say that the statute does not provide for consent to treatment, treatment plans, for time-limited use of involuntary treatment, or for independent or periodic review of any such treatment.	

	c) √		
• Treatment is necessary to bring about an improvement in the patient's condition and/or restore capacity to make treatment decisions and/or prevent serious deterioration and/or prevent injury or harm to self or others.	a) b) c) √		
2) Does the law ensure that a treatment plan is proposed by an accredited practioner with expertise and knowledge to undertake treatment?	a) b) c) √		
3) Does the law make provision for a second practitioner to agree on the treatment plan?	a) b) c) √		
4) Is an independent body set up to authorise involuntary treatment?	a) b) c) √		
5) Does the law ensure that treatment is for a time limited period only?	a) b) c) √		
6) Does the law provide a right to appeal an involuntary treatment?	a) b) c) √		
7) Are there speedy time-bound periodic reviews of involuntary treatment in the	a)		

legislation?	*b)* **c)** √		
K. Proxy consent for treatment 1) Does the law make provision for a person to consent to treatment on a patient's behalf if they have been found incapable of consenting? 2) Are patient's given the right to appeal in circumstances of proxy consent? 3) Is provision made in legislation for an "Advance Directive"?	*a)* *b)* **c)** √ *a)* *b)* **c)** √ *a)* *b)* **c)** √	**1)—3)** The statute does not provide for proxy decision making or advance directives for patients incapable of consenting to treatment. Not having provisions for proxy decision making means either that patients are consenting to treatment even though they are incapable of making decisions, or else are being denied treatment because of that incapacity. Although many persons with mental disorders have capacity to make decisions, for those who do not, surrogate or proxy decision making can provide an alternative way of proceeding that respects the person's autonomy and interests to the maximum extent possible.	
L. Involuntary treatment in community settings 1) Does the law provide for involuntary treatment in the community as a "less restrictive" alternative to an in-patient mental health facility? 2) Are all the criteria and safeguards required for involuntary inpatient treatment included for involuntary community treatment?	*a)* *b)* **c)** √ *a)* *b)* **c)** √	**1), 2)** The statute does not provide for involuntary treatment in the community as a "less restrictive" alternative to in-patient care. Other than mentioning that voluntary patients may be treated either as in-patients or out-patients (Part II, Para. 6 (2)), the statute is silent on community-based care, however provided. In accordance with Principle 9 (1) of the MI Principles, every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others. Examples of less restrictive environments could include home-based care, day hospital treatment and out-patient treatment. Community supervised orders can also be used where patients are required to reside at a specific location and attend regular treatment programmes in the community.	
M. Emergency situations 1) Is the criteria for emergency	*a)*	**1)** Although Part III, Para. 10., provides criteria for emergency or urgent care, those criteria are quite vague and present a serious opportunity for abuse. Para. 10. (1), permits detention *"in a case of urgency,"* when a medical officer determines *"it is expedient either for the welfare of the person suspected. . . to be*	

admission/treatment limited to situations where there is a high likelihood of immediate and imminent danger or harm to self and/or others?	b) √ c)	*suffering from a mental illness, or for the public safety, that such person should be forthwith placed under care, observation, or treatment."* Admitting a person simply because he or she has a mental disorder cannot be regarded as an emergency, and would constitute a violation of human rights. The public safety prong of the definition is not limited to cases where there is a high likelihood of immediate and imminent danger to self or others.	
2) Is there a clear procedure in the law for admission and treatment of emergencies?	a) √ b) c)	**2)** There seems to be a clearly defined procedure for admission in urgent cases. Part V, Para. 10. (1), provides that a "registered medical practitioner" (not defined in the statute, however) must certify the case as one of urgency. Urgent cases can be immediately admitted to a psychiatric hospital, but Part V, Para.10. (2) provides that if immediate admission to a psychiatric hospital is impracticable, a patient can be moved to a place of safe custody before transfer to a hospital. If the person is admitted to the place of public safety, he or she must be transferred to a psychiatric hospital within 5 days, whereupon he can be held for up to another 14 days.	
3) Does the law allow any qualified and accredited medical or mental health practitioner to admit and treat emergency cases?	a) b) √ c)	**3)** As discussed in the previous section, a "registered medical practitioner" must certify admission of an urgent case. The statute is silent on whether there is any special qualification or accreditation needed to treat a patient so admitted, but presumably anyone can do so.	
4) Does the law specify a time-limitation for emergency admission (usually not longer than 72 hours)?	a) √ b) c)	**4)** As discussed in section 2 above, the statute does specify a time limit for emergency admission. However, the time limit is much longer than 72 hours. Rather, it is 14 days or, if the person is transferred from a place of public safety, 19 days. Such a lengthy period of "emergency" detention raises serious human rights issues.	
5) Does the law specify the need to initiate the procedures for involuntary admission and treatment, if needed, as soon as possible after the emergency situation?	a) b) √ c)	**5)** While the statute requires that procedures for initiating involuntary admission must be started before the end of the 14 (or 19) day period of urgent admissions, there is no requirement that such procedures be activated as soon as possible after the emergency admission. While scarce resources might make a 72-hour limitation on emergency admissions difficult to meet, a 14- or 19-day waiting period is an excessive time to wait before starting longer-term commitment procedures.	
6) Are treatments such as ECT and psychosurgery as well as participation in clinical or experimental trials outlawed for people held as emergency cases?	a) b) c) √	**6)** Because treatments such as ECT, psychosurgery and participation in clinical research trials are not mentioned in the law (see section O, below), there are no provisions limiting such modalities for emergency patients or in fact any other voluntary or involuntary patient.

7) According to Part IV, Para. 16, any person (presumably including patients, their families and personal representatives) has the right to apply to the Mental | |

7) Do patients, family members and personal representatives have the right to appeal against emergency admissions/treatments?	a) b) √ c)	Health Review Tribunal to review, among other things, the conditions under which a person is detained. Presumably, this language is broad enough to include challenging emergency treatments or admissions. However, this right of application is not an appeal as such, but rather relief in the nature of habeas corpus in which current conditions of confinement may be challenged (as opposed to the original decision being appealed).	
N. Determinations of Mental Disorder 1) Does the legislation a) define the level of skills required to determine mental disorder? b) specify the categories of professionals who may assess a person to determine the existence of a mental disorder? 2) Codify the accreditation of practitioners in law and ensure that it is operated by an independent body?	 a) b) √ c) a) b) √ c) a) b) c) √	**1) a)** The legislation in part defines the level of skill required to determine a mental disorder. Under Part III, Para. 8. (1), *"two medical recommendations"* must support a request for the magistrate to order temporary treatment of the patient (for up to six months). Pursuant to Para.8. (2), one of these medical recommendations "*shall be from a practitioner experienced in psychiatry."* For prolonged treatment under Part III, Para. 9. (2), (3), the statute requires one medical recommendation from a practitioner experienced in psychiatry. The above references to "medical recommendations" do not set out the level of medical expertise required to make the recommendation. The "practitioner experienced in psychiatry" provides important additional language, but the statute might go further by stating the level of experience in terms of years worked in psychiatry or mental health qualifications. **b)** The categories of professionals who may assess a person to determine the existence of a mental disorder are not well-defined. The statute does not define the category of professional empowered to make the "medical recommendation" described above. The "practitioner experienced in psychiatry" provides additional clarification but is still ambiguous. The law needs to be clear on the different categories of mental health /health professionals who may determine mental disorder. In many African countries, primary health care is predominantly provided by trained general nurses (there is no mention of nurses in the legislation). If decentralization is to be effective, the role of the primary health care provider should be defined. It is not possible in resource poor settings to expect only mental health professionals to provide this service. It may become necessary to empower the primary health care worker with skills in simple identification of mental disorders through training programmes at the community level. **2)** The law does not codify the accreditation of practitioners.	
O. Special treatments 1) Does the law prohibit sterilisation as a treatment for mental disorder? a) Does the law specify that the mere fact of having a mental	 a) b) c) √ a) b)	**1)--4)** The statute does not refer to any special treatments; thus, it is silent regarding whether informed consent is needed for sterilization, abortion, major medical and surgical procedures, psychosurgery, and ECT (whether or not unmodified). It is not clear how many of these special treatments are in fact used in Ghana. For example, in many African countries, abortion	

disorder should not be a reason for sterilisation or abortion without informed consent	*c)* √	is illegal, although the rights of people with mental disorders have been known to have been violated simply because society perceived sterilization of these individuals to be appropriate. Part V, Para. 19, authorizes transfer of a patient of a psychiatric hospital to another hospital where necessary, but does not set out any procedures for performing treatment there (including the need for informed consent, as well as any exceptions, such as in emergencies).
2) Does the law require informed consent for major medical and surgical procedures on persons with mental disorder?	*a)* *b)* *c)* √	
a) Does the law allow medical and surgical procedures without informed consent if waiting for informed consent would put the patient's life at risk?	*a)* *b)* *c)* √	
b) In cases where inability to consent is likely to be long term does the law allow authorisation for medical and surgical procedures from an independent review body or by proxy consent of a guardian?	*a)* *b)* *c)* √	
3) Is psychosurgery and other irreversible treatments outlawed on involuntary patients? a)Is there a independent body that ensures that there is indeed informed consent for psychosurgery or other irreversible treatments on involuntary patients?	*a)* *b)* *c)* √ *a)* *b)* *c)* √	
4) Does the law specify the need for informed consent when using ECT?		

a) Are adequate procedures laid down in legislation for exceptional cases of using ECT without informed consent but with the approval of a court , tribunal or other review body? b) Does the law prohibit use of unmodified ECT?	*a)* *b)* *c)* √ *a)* *b)* *c)* √ *a)* *b)* *c)* √		
P. Seclusion and Restraint 1) Does the law state that seclusion and restraint should only be utilised in exceptional cases to prevent immediate or imminent harm to self or others? 2) Does the law specify a restricted maximum time period for which seclusion and restraints can be used? 3) Does the law encourage the development of appropriate structural and human resource requirements that minimise the need to use seclusion and restraints in mental health facilities? 4) Does the law lay down adequate	 *a)* *b)* *c)* √ *a)* *b)* *c)* √ *a)* *b)* *c)* √	**1)- 3)** The statute does not address seclusion and restraint. The law needs to be clear on issues of restraint and seclusion because these practices lead to some of the most common forms of human rights violations regarding people with mental disorders. Seclusion and restraint should only be used, if at all, when they are the only means available to prevent immediate or imminent harm to self and others, and then for the shortest period of time necessary (for minutes or at most a few hours). Seclusion and restraint are never appropriate as means of punishment or for the convenience of staff.	

procedures for the use of seclusion and restraint including: • Who should authorise it • That the facility should be accredited • that the reasons and duration of each incident be recorded in a database and made available to a review board • that family members/carers and personal representatives be immediately informed when the patient is subject to seclusion and restraint	*a)* *b)* *c)* √	**4)** Because the statute does not address seclusion and restraint, it does not set out any procedures for their use. The statute must address who can authorize seclusion and restraint; whether only accredited facilities can avail themselves of these options; limitations on the permissible purposes and duration of seclusion and restraint, with documentation of such, available for independent outside review; and immediate notice to family members, carers, and personal representatives of the patient when these procedures are used.	
Q. Clinical and Experimental Research 1) Does the law state that informed consent must be obtained for participation in clinical or experimental research from both voluntary and involuntary patients who have the ability to consent? 2) Where a person is unable to give informed consent (and where a decision has been made that research can be	 *a)* *b)* *c)* √	**1)** The statute does not address clinical or experimental research. Thus, it does not provide for obtaining informed consent from voluntary and involuntary patients with the ability to consent for participation in clinical or experimental research. **2 a)** The statute does not provide for proxy consent for participation in research by patients unable to give informed consent.	

conducted) a) Does the law ensure that proxy consent is obtained from either the legally appointed guardian/family member or from an independent authority constituted for this purpose? b) Does the law state that the research cannot be conducted if the same research could be conducted on people capable of consenting and that the research is necessary to promote the health of the individual him/herself and that of the population represented?	*a)* *b)* *c)* √ *a)* *b)* *c)* √	The statute does not address the requirement that research be conducted on people capable of giving informed consent or that any research on people incapable of giving consent be justified as necessary to promote the health of the individual and the population the individual represents. The statute only addresses informed consent in Part II, Para. 7 (3), Voluntary Admission, when it provides that if a patient cannot express his intentions regarding discharge, the chief administrator may discharge the person to a relative or other suitable person, subject to certain conditions.	
R. Oversight and Review Mechanisms 1. Does the law set-up a Judicial or quasi-judicial body to review **processes related to** involuntary admission/treatment and other restrictions of rights **1a. Does the above body:** (i). Assess each involuntary admission/ treatment (ii). Entertain appeals against involuntary admission and/or	*a)* *b)* √ *c)* *a)* *b)* √ *c)* *a)* *b)* √	**1)** The statute establishes a Mental Health Review Tribunal in Part IV, Paras. 15-17. The Tribunal comprises five members, with a legal practitioner as chairman, a psychiatrist, a medical practitioner, and two other persons appointed by the Commissioner. The Tribunal, however, does not appear explicitly to review "processes related to involuntary admission/treatment and other restrictions of rights." **1a. (i)** This body does not assess each involuntary admission/treatment. However, a person (or someone on his behalf) can request the Tribunal to *"review the conditions under which he is detained; or request. . . his discharge; or request. . . any other appropriate action."* (Part IV, Para. 16). **1a. (ii)** This body does not explicitly entertain appeals from involuntary admission or treatment, but has the language quoted in the previous section.	

involuntary treatment;	c)		
(iii). Review the cases of patients admitted on an involuntary basis (and long term voluntary patients);	a) b) √ c)	**1a. (iii)** This body does not systematically review the cases of patients admitted on an involuntary basis (and long-term voluntary patients), though, presumably, it can be asked to review such cases pursuant to the language quoted in 1a.(i) above.	
(iv). Regularly monitor patients receiving treatments against their will;	a) b) c) √	**1a. (iv)** The body does not appear to regularly monitor patients receiving treatment against their will.	
(v). Authorize intrusive and irreversible treatments	a) b) c) √	**1a. (v)** The body does not appear to authorize or address the implementation of intrusive and irreversible treatments (which are not discussed in the statute).	
1b. Does the composition of this body include an experienced legal and experienced health and a "wise person reflecting a "community" perspective.	a) b) √ c)	**1 b.** The Tribunal includes a legal practitioner (as chairman), a psychiatrist, and another medical practitioner. There is no requirement that these individuals have any particular level of experience. The Commissioner appoints two additional people to the Tribunal, but there is no requirement that they necessarily reflect a "community perspective." There is no apparent role for self- advocates on the Tribunal.	
1c. Does the law allow for appeal of this bodies decisions to a higher court?	a) b) c) √	**1 c**. The statute does not provide for appeal of the Tribunal's decisions to a higher court.	
2) Does the law set up **a regulation and oversight** body to protect the rights of people with mental disorders within and outside mental health facilities?	a) b) √ c)	**2)** The statute creates visiting committees for each psychiatric hospital (Part I, Para. 4). The Commissioner must appoint committees of three or more visitors. The visiting committees do not appear to operate "outside mental health facilities."	
2a) Does the above body	a) √	**2a)(i)** The visiting committee does conduct regular inspections of	

(i) Conduct regular inspections of mental health facilities;	*b)* *c)*	psychiatric hospitals. Under Part I, Para. 4, the visiting committee meets at the hospital at least quarterly and conducts inspections, examines books and accounts, and investigates any complaints.
(ii) Provide guidance on minimising intrusive treatments	*a)* *b)* *c)* √	**2a)(ii)** The visiting committee does not appear to have the authority to provide guidance on minimizing intrusive treatments (though it could presumably receive complaints about such treatments).
(iii) Maintain statistics, for example use of intrusive and irreversible treatments, seclusion and restraints.	*a)* *b)* *c)* √	**2a)(iii)** The visiting committee does not appear to maintain statistics on intrusive and irreversible treatments or other matters, though it is required to submit a written report to the Commissioner after each quarterly visit, indicating places visited and whether or not conditions were satisfactory, and making any recommendations it deems appropriate (Part I, Para. 4 (3)).
(iv) Maintain registers of accredited facilities and professionals	*a)* *b)* *c)* √	**2a)(iv)** The visiting committee dos not maintain registers of accredited facilities and professionals.
(v) Report and make recommendations directly to the appropriate government minister.	*a)* √ *b)* *c)*	**2a)(v)** The visiting committees, as indicated above, are required to make quarterly reports to the Commissioner, through the Director of Medical Services.
		2a)(vi) It does not appear that the visiting committees publish their findings on a regular basis, or at all.
(vi) Publish findings on a regular basis	*a)* *b)* *c)* √	Public reports on conditions in psychiatric facilities, with appropriate protections for patient privacy and confidentiality, can provide an important check on abuses within institutions and create an avenue for public focus on institutional conditions.
2b) Does the composition of the body include professionals (mental health, legal, social work), representatives of users of mental health facilities, members representing families of people with mental disorders, advocates, and	*a)* *b)* √ *c)*	**2b)** As noted, the visiting committees have three professionals (a legal practitioner, a psychiatrist, and a medical practitioner) and two additional people. While these people can presumably be drawn from family members, advocates, and mental health system users, there is no requirement that they represent these groups or their interests.

lay persons depending on the resources available.		
2c) Is the authority this body has clearly stated in the legislation	*a)* √ *b)* *c)*	**2c)** The visiting committee's authority is clearly stated in the statute, though its powers are mostly in the nature of observing and reporting to the Commissioner rather than acting on their own.
3) Does the legislation outline procedures for submissions, investigations and resolutions of complaints?	*a)* *b)* *c)* √	**3)** The statute does not outline procedures for visiting committees for submission, investigation, and resolution of complaints, though, as noted, these committees are authorized to receive complaints *"preferred by or against any officer, staff or patient."* Part I, Para. 4 (2) (c).
3b) Does the law stipulate		
The time period from the occurrence of the incident within which the complaint should be made?	*a)* *b)* *c)*	
A maximum time period within which the complain should be responded to, by whom and how?	*a)* *b)* *c)*	
The right of patients to choose and appoint a personal representative and/or legal counsel to represent them in any appeals or complaints procedures?	*a)* *b)* *c)*	
The right of patients to an interpreter during the proceedings, if necessary?	*a)* *b)* *c)*	
The right of patients and their counsel to		

access copies of their medical records and any other relevant reports and documents during the complaints or appeals procedures?	a) b) **c)**		
The right of patients and their counsel to attend and participate in complaints and appeals procedures?	a) b) **c)**		
S. Police Responsibilities 1) Does the law place restrictions on the activities of the police to ensure that persons with mental disorders are protected against unlawful arrest and detention and are directed towards health care services?	a) **b)** √ c)	**1)** The statute gives the police broad power, pursuant to a warrant issued by a magistrate, to seek out a person believed to be suffering from mental illness who is either being ill-treated or neglected or is living alone and unable to care for himself, and *"to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to [applying for temporary commitment for up to six months or making] other arrangements for his treatment or care."* Part V, Para. 22 (1). The police officer, where practicable, should be accompanied by a mental welfare officer and by a medical practitioner. The individual may be detained for no more than 72 hours. Under Part V, Para. 23 (1), the police may detain without a warrant (also for up to 72 hours) a person in a public place *"who appears to him to be suffering from mental illness and to be in immediate need of care or control."* While these provisions could serve to protect the rights of people with mental disorders, and do entail transferring the individual to the mental health system within a relatively brief period, they also present opportunities for mischief, in that the standard for intervention is vague and subject to varying interpretations. It also is not clear how these two provisions relate to the urgent commitment provisions referred to in Part II, Para. 10. Police officers are often the first professionals to come into contact with persons who may be suffering from a mental disorder. It is critical that the police receive training in mental health and related areas to permit them to carry out their responsibilities in an appropriate manner.	
2) Does the legislation allow family members, carers or health professionals to get police assistance in situations where a patient is highly aggressive or is showing out of control behaviour	a) b) √ **c)**	**2)** The above provisions, especially Para. 22 (1), *might* permit a family member, carer or health professional to contact the police and get assistance in dealing with a patient who is highly aggressive or out of control, though they appear oriented more toward protecting the person who is being ill-treated or neglected by his caregivers.	
3) Does the law allow for persons arrested for criminal acts and in police custody to be promptly assessed for mental disorder if there is suspicion of mental disorder?	a) b) **c)** √	**3)** The statute does not provide for prompt assessment of arrestees for the presence of a mental disorder when there is a suspicion that such disorder exists. The only provision addressing the intersection between the mental health system and the criminal justice system is in Part V, Para. 20, which permits (but does not require) the Commissioner to establish (a) state psychiatric hospital(s) for treatment of persons facing criminal proceedings or currently in prison. Para. 20 (2) further requires that any such hospital shall *"assist the rehabilitation"* of any such person committed to the institution.	
4) Does the law make provision for the police to assist in removing a person	a)	**4)** The statute does not provide for police assistance in removing a person who has been involuntarily admitted to a mental health	

who has been involuntarily admitted, to a mental health facility? 5) Does the legislation make provision for police to find an involuntarily committed person who has absconded and return them to the mental health facility?	*b)* *c)* √ *a)* *b)* *c)* √	facility. **5)** The statute makes no provision for the police to find and return to a mental health facility an involuntarily committed person who has escaped.	
T. Mentally Ill Offenders 1) Does the legislation allow for transferring a person to mental health care rather then prosecuting them – taking into account the gravity of the offence; the person's psychiatric history, mental health state at the time of the offence; the likelihood of detriment to the person's health and the communities interest in prosecution? 2) Does the law make adequate provision for people who are not fit to stand trial to be assessed and for charges to be dropped or stayed while they undergo treatment? a) Are people undergoing such treatment given the same rights in the law as other civilly committed persons, including the right to judicial review by an independent body?	*a)* *b)* √ *c)* *a)* *b)* *c)* √ *a)* *b)* *c)* √	**1)** The statute does not provide for diverting an individual from the criminal justice system to the mental health care system where appropriate to do so. However, Part V, Para. 20 discussed in the previous section implicitly recognizes that such transfers might be appropriate. It is not clear at what point in the criminal proceedings an individual might be transferred to a state psychiatric hospital (assuming the Commissioner has created a facility or facilities for this purpose). **2), 2)a)** The statute does not address assessment of individuals who may be incompetent to stand trial, nor does it address what happens to pending criminal charges while the person is undergoing treatment.	

3) Does the law allow for people who are found by the courts to be Not Responsible Due to Mental Disability to be treated in a mental health facility and to be discharged once their mental disorder sufficiently improves?	a) b) c) √	3) The statute does not address persons who are found not responsible by reason of mental disability.	
4) Does the law allow at the sentencing stage for persons with mental disorders to be given probation or hospital orders rather than being sentenced to prison?	a) b) c) √	4) The statute does not address sentencing alternatives for defendants suffering from mental disorders.	
5) Does the law allow for the transfer of a convicted prisoner to a mental health facility if they become mentally ill while serving their sentence?	a) b) √ c)	5) Part V, Para. 20, implicitly provides for transfer of a convicted prisoner to a mental health facility if the person becomes mentally ill while serving his or her sentence (assuming the facilities have been opened for this purpose). However, there are no statutory procedures regulating these transfers.	
a) Does the law prohibit keeping a prisoner in the mental health facility for longer than their sentence unless civil commitment procedures are followed?	a) b) c) √	5) a) The statute does not address the length of commitment of prisoners who complete their criminal sentence but are still in the psychiatric hospital.	
6) Does the legislation provide for secure facilities for people with mental disorders	a) √ b) c)	6) The statute permits the Commissioner to establish facilities (which presumably could be secure facilities) for people with mental disorders, at least for those facing criminal proceedings or transferred from prison.	
U. Discrimination			
1) Does the law include provisions aimed at stopping discrimination against	a) b)	1) The statute does not address discrimination against people with mental disorders.	

people with mental disorders?	*c)* √		
V. Housing			
1) Does the law ensure non-discrimination of people with mental disorders in the allocation of housing?	*a)* *b)* *c)* √	**1)** The statute does not address non-discrimination against people with mental disorders in the allocation of housing.	
2) Does the law make provision for the housing for people with mental disorders in state housing schemes or through subsidised housing?	*a)* *b)* *c)* √	**2)** The statute does not address providing state-subsidized housing for people with mental disorders.	
3) Does the legislation make provision for housing in half-way homes and long-stay supported homes for people with mental disorders?	*a)* *b)* *c)* √	**3)** The statute does not provide for halfway houses or long-term supported living arrangements for people with mental disorders.	
W. Employment			
1) Does the law make provision for protection of persons with mental disorders from discrimination and exploitation in the workplace?	*a)* *b)* *c)* √	**1 through 3)** The statute does not provide for protection of people with mental disorders against employment discrimination, nor does it provide for establishment of vocational rehabilitation programs or other employment programs in the community.	
2) Does the law provide for equal employment opportunities for people with mental disorders?	*a)* *b)* *c)* √		
3) Does the law make provision for the establishment of vocational	*a)* *b)*		

rehabilitation programmes and other programmes for jobs and employment in the community?	c) √		
X Social Security 1) Does legislation provide for disability grants/pensions for people with mental disabilities? 2) Does the law provide for disability grants/pensions for people with mental disorders at a similar rate as those for people with physical disabilities?	a) b) c) √ a) b) c) √	**1 and 2)** The statute does not provide for disability grants or pensions for people with mental disabilities, and does not address the equity between any grants or pensions for people with physical and mental disorders.	
Y. Civil Issues 1) Does the law enforce the rights of people with mental disorders to the full range of civil, political, economic, social and cultural rights that all people are entitled?	 a) b) c) √	**1)** The statute does not address the civil, political, economic, social and cultural rights of people with mental disorders.	
Z. Protection of Vulnerable Groups **i. Protection of Minors** 1) Does the law limit the involuntary placement of minors in mental health	 a) b)	**1)** The statute does not limit involuntary commitment of minors to facilities only after community alternatives have	

facilities to instances where all feasible community alternatives have been tried?	*c)* √	been tried.
2) If minors are placed in mental health facilities, does the legislation stipulate that they should have a separate living area from adults?	*a)* √ *b)* *c)*	**2)** Part V, Para. 26 (2) provides that *"All children under the age of sixteen years in a psychiatric hospital shall be accommodated separately from older persons."*
3) If minors are placed in mental health facilities, does the legislation ensure that the environment is age appropriate and takes into consideration the developmental needs of minors?	*a)* *b)* *c)* √	**3)** The statute does not provide for an age- and developmentally-appropriate environment for minors.
4) Does the law ensure that all minors have an adult to represent them in all matters affecting them – including consenting to treatment?	*a)* *b)* *c)* √	**4)** The statute does not ensure that minors have an adult represent them in all matters, including consenting to treatment.
5) Does the law stipulate the need to take the opinions of minors into consideration in all issues affecting them (including consent to treatment) depending on their age and maturity?	*a)* *b)* *c)* √	**5)** The statute does not address the need to take into account the opinions of minors on issues affecting them.
6) Does legislation ban all irreversible treatments on children?	*a)* *b)* *c)* √	**6)** The statute does not address irreversible treatments for children, and consequently does not ban such treatments.

ii. Protection of Women		
1) Does legislation allow women with mental disorder equal rights with men in all matters relating to civil, political, economic, social and cultural rights, consent to treatment etc?	a) b) c) √	1), 4) The statute does not have language addressing equal rights of women with mental disorders.
2) Does the law ensure that women in mental health facilities have adequate privacy?	a) b) c) √	2) The statute does not address the privacy rights of women patients (other than in the next section).
3) Does the law ensure that women in mental health facilities are provided with separate sleeping facilities from men?	a) √ b) c)	3) Part V, Para. 26 (1) provides that female patients are to be accommodated separately from male patients.
4) Does legislation state that women with mental disorders receive equal mental health treatment and care as men including care in the community and in relation to voluntary and involuntary admission and treatment?	a) b) c) √	
iii. Protection of Minorities		
1) Does legislation specifically state that persons with mental disorder should not be discriminated against on the grounds of race, colour, language, religion, political or other opinion, national, ethnic or social origin, legal or social status?	A) b) c) √	1). 2) The statute does not address the rights of minorities.

2) Does the legislation provide for the Review Body to monitor involuntary admissions and treatments and ensure non-discrimination on all matters regarding minorities?	*a)* *b)* *c)* √		
AZ. Offences and Penalties 1) Does the law have a section dealing with offences and adequate penalties	*a)* *b)* *c)* √	**1)** The statute does not make any provisions for offences and penalties.	

7.2.2 Checklists for Evaluating a Mental Health Policy and Plan

CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY.

Introduction

Once a policy/draft policy has been drawn up in a country, it is important to conduct an assessment of whether certain processes have been followed that are likely to lead to the success of the policy; and whether various content issues have been addressed and appropriate actions included in the policy. This checklist is intended to assist with this evaluation.

While the checklist is limited in that it does not enable assessment of the *quality* of the processes or contents of the policy, evaluators are encouraged, when completing the checklist, to consider the *adequacy* of both the process and content. Particularly where a response is "no" or "to some extent", it is suggested that they provide either an action plan to remedy the situation or a comment.. (In some instances the comment may, for example, merely be that a particular action is covered in a different policy, or that it is not possible to implement given the current resources available). The different modules in the WHO *Mental Health Policy and Service Guidance Package* can be consulted for more guidance on how to address relevant sections and for a better understanding of the policy issues mentioned in the checklist.

This checklist may usefully be completed by those who drafted the policy and/or by employees in the government itself. However, it is also important to have *independent reviewers.* Those involved in drawing up the policy may have personal or political interests or may be "too close" to the policy to see anomalies or provide critical input. Ideally, therefore, an independent multidisciplinary team should be convened to conduct an evaluation. A team is also advantageous as no single person is likely to have all the relevant information required, and debate is crucial for arriving at an optimal policy for the country. Furthermore, when relevant interest groups have been involved in the process of the development of the policy and/or in their evaluation, which leads to changes being made to the policy, it is likely that they will be more effectively implemented. It would be useful to include consumer organizations, family organizations, service providers, professional organizations and NGOs, as well as representatives of other government departments affected by the policy.

Finally, although the checklist should be "scored" in terms of the mental health policy document, it is important to have, or be familiar with, other relevant and related documentation. Often items are not covered in the mental health policy because they are comprehensively covered elsewhere. For example, policies on health information systems or human resources may include mental health and are therefore deliberately not repeated in the mental health policy. This explanation should then be noted in the relevant section.

Organisation, Prof Melvyn Freeman, Human Sciences Research Council, Pretoria, South Africa and Dr Sheila Ndyanabangi, Ministry of Health Uganda.

CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY

Please use the following rating scale to rate each item: 1 = yes/ to great degree 3 = no/not at all 2 = to some extent 4 = unknown	Rating	If "yes" or "to some extent" please state how. If not, please state reason(s).	Action required (if any)
PROCESS ISSUES			
1a. Was there a high-level mandate to develop the policy (e.g. from the Minister of Health)?	1	Director General chief psychiaitrist as advisor to the minister of health was also involved	
1b. At what level has the policy been officially approved and adopted? (e.g., the department of mental health, Ministry of Health, Cabinet, Minister of Health).	1	Director general of health services	
2. Is the policy based on relevant data:			
-- From a situation assessment?	2	**The national coordinator and the head of psychiatry of the ugms came to assesss the situation. High powered tour**	
-- From a needs assessment?	1	**The abaove pple were on the gorund and knew what was required. Intimate knowledge of the situation on the ground**	
3. Have policies relating to mental health that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where relevant?	2	**Not all the policies are fully implementd. Consultation with other countries was not extensive**	**More re3esources to be allocated to improve the implementation**
4. Has a thorough consultation process taken place with the following groups:			
-- Representatives from the Health Sector, including planning, pharmaceutical , human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions.	2	**Planning Officer, Medical Directors of the psychiatric hospitals, in consultation with the Ministry, PPME and Health Research Directorate were involved but not the others** People were working independently. Policy drawn up in a hurry. No budget for the policy process	Better intersectoral collaboration.
-- Representatives from the Finance Ministry?	3	The process was quite hurriedly drawn and did not involve much collaboration and	

		consultation.	
-- Representatives from Social Welfare and Housing Ministries?	3	dito	
-- Representatives from the criminal justice system?	3	dito	
-- Consumers, or representatives of consumer groups?	3	The process was quite hurriedly drawn and did not involve much collaboration and consultation. Also there were no strong consumer groups to be involved in the consultations	
-- Family members or their representatives?	3	The process was quite hurriedly drawn and did not involve much collaboration and consultation. Also there were no strong family groups to be involved in the consultations	
-- Other NGOs?	1	Basic Needs (Ghana) was very much involved in the consultation and collaboration processes	
-- Private sector?	3		
-- Any other key stakeholder groups? If so, please list them	1	**WHO, Royal Netherlans Embassy were involved. The Royal Netherlands Embassy gave financial support but did not sit in the deliberations.**	
5. Has an exchange taken place with other countries concerning their mental health policies and experiences?	2	**Exchange programme with Nigeria**	**A closer look at the Ugandan policy and the effect our policy has on Nigeria**
6. Has relevant research been undertaken to inform policy development, (e.g. pilot studies)?	2	**Student thesis and dissertations, quality assurance researches in the hospitals**	These researches should be included more officially, and a reference list included as part of the policy with subsequent revisions. Also researches from the Health Research Centres of the Ministry of Health should be extensively consulted.
CONTENT ISSUES			
1. Is there a realistic vision statement?	1	It fits into the Min of Health's vision of	**To sharpen the wording of the vision**

		attaining middle income status by 2010 through health. It's also compatible with the National vision.	**statement to make it more catchy**
2. Are values and associated principles which inform the policy included?	**1**	Not found in the vision, but the principles are spread throughout the document.	
3. Do these values and associated principles emphasize and/or promote:			
-- Human rights?	**1**	Human rights issues are extensively discussed	
-- Social inclusion?	**1**		
-- Community care?	**1**	Community psychiatric nursing is quite available	
-- Integration?	**1**	The policy states that mental health should be on the same pedestal as physical health	Difficult in practice .since the mentally ill are not covered when they get physically ill. The national health insurance scheme needs to be modified. Could be taken up with the Disability Act when it is being fully implemented
-- Evidence-based practice?	**2**	Not much evidence-based information was cited	Research into best practices in mental health should be stepped up
-- Intersectoral collaboration?	**2**	Only the Ministry of Manpower Youth and Employment was consulted.	The collaboration should be broadened in subsequent policy processes as a way of ensuring higher degrees of success during implementation
-- Equity with physical health care?	**1**	Mental health care has been put on the same pedestal as physical health, in principle	Difficult to obtain the free coverage outside the mental hospitals
4. Have clear objectives been defined?	**1**		
5. Are objectives consistent:	**1**		
-- With the vision?	**1**	The objectives tally to a great extent with the vision	
-- With the values and principles?	**1**	…and with the general values and principles of mental health care	

6. Are the areas for action clearly described to indicate the main policy directions and what will be achieved?	1	There are output indicators for the objectives	
7. Are the areas for action written in a way that commits the Governmen t (e.g. do they state "will" instead of "should")?	3	The style of writing is non-commital: looks more like an action plan. The draft law is more committing.	
8. To what extent do the areas for action comprehensively address **coordination & management?**	1	It talks about coordination with several sectors. Management issues were dealt with in a separate handbook	Integration of management and coordination in the same document would facilitate implementation processes
(a) Does the policy specify a dedicated mental health position/post within the Ministry of Health to coordinate mental health functions and services?	1	The mnetal health unit at the Institutional Care Division of the Ghana Health Service has been mandated to do the coordination. In the communities it is under public health	
(b) Does the policy establish or refer to a multisectoral coordinating body to oversee major decisions in mental health?	1	There is a technical coordinating committee comprising representatives of various ministries	In practice, the committee is not in existence
9) To what extent do the areas for action comprehensively address **financing?**	2	Mentions free drugs but does not talk about how much money should get there and from where	
(a) Does the policy indicate how funding will be utilized to promote equitable mental health services?	2	Source of money not addressed in the policy or the bill.	
(b) Does the policy state that equitable funding between mental health and physical health will be provided?	1	It is stated in the law	Adjustments in the national insurance scheme is needed to addresss this issue. Passing of the mental health lawwould also facilitate this.
(c) If health insurance is utilized in the country, does the policy indicate whether/how mental health would be part of it?	3	The health insurance does not cover mental disorders	Get it included in the law
10. To what degree do the areas for action comprehensively address **legislation and/or human rights?**	1	Not specifically mentioned in the policy	
(a) Does the policy promote human rights?	1	The 1972 Mental Health Decree, but the 2006draft law talks extensively about human right.	
(b) Does the policy promote the development and implementation of human-rights-oriented legislation?	1	Comprehensively addressed in the draft	

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		mental health law	
(c) Is the setting up of a review body envisaged to monitor different aspects of human rights?	**1**	Visiting committees, human rights tribunals	Tribunals are not yet in place
11. To what extent do the areas for action comprehensively address **organization of services?**	**1**	Comprehensively addressed in the draft mental health law	
(a) Does the policy promote the integration of mental health services into general health services?	**1**	ditto	
(b) Does the policy promote a community-oriented mental health approach?	**1**	ditto	
(c) Does the policy promote deinstitutionalization?	**1**	Ditto	
12. To what extent do the areas for action comprehensively address **promotion, prevention and rehabilitation?** Does the policy make provision for:			
(a) The prevention of mental disorders?	**1**	As in 11 above	
(b) Interventions that promote mental health?	**1**	ditto	
(c) Interventions for the rehabilitation of people with mental disorders?	**1**	Ditto	
13. To what extent do the areas for action comprehensively address **advocacy?**	**1**	School health educational programmes, substance abuse discussions	
(a) Is the policy supportive of consumers and family organizations?	**1**	Meetings with family support groups	
(b) Is there emphasis on raising awareness of mental disorders and their effective treatment?	**1**	It is the fifth strategic objective of the policy	
(c) Does the policy promote advocacy on behalf of people with mental disorders?	**1**	The strategic objective 1 of the policy states this	
14. To what extent do the areas for action comprehensively address **quality improvement?** Does the policy			
(a) Make a commitment to providing high quality, evidence- based interventions?	**1**	As part of quality assurance	
(b) Include a process to measure and improve the quality of services?	**1**	Monitoring and evaluation as part of quality assurance	

15. To what extent do the areas for action comprehensively address **information systems?**	1	As part of the draft law. However the tools are not adequate	
(a) Will mental health information systems be set up to guide decision-making for future policy, planning and service development?	1	As above	
16. To what extent do the areas for action comprehensively address **human resources and training?**	2	Mentioned both in the policy and the 1972 decree but does not comprehensively describe the process to be involved	
(a) Does the policy commit to putting in place suitable working conditions for mental health providers?	3	Not captured. Safety of mental health workers, risk allowance, safer environments , programmes for prevention and safety, extra insurance cover for them are not addressed. Serious oversight.	Future policies must address this issue as a matter of prority.
(b) Have appropriate management strategies been discussed to improve recruitment and retention of mental health providers?	2	Comprehensive coverage in the 2nd 5-year programme of Action 2007-2011. Mental health has not much say in recruitment as this is done by Min of Health. Mental health unit's responsibility is retention	A revised policy should establish a training scheme and recruitment power should be given to the mental health unit
(c) Are training in core competencies and skills seen as central to human resources development?	1	Talks about in-service training but does not stress core competencies	
17. To what extent do the areas for action comprehensively address **research and evaluation?**	1	Mentioned in terms of quality assurance, ethics research, good governance strategies	
(a) Does the policy emphasize the need for research and evaluation of services and of the policy and strategic plan?	1	Mentioned in terms of quality assurance, ethics research, good governance strategies	
18. To what extent do the areas for action comprehensively address **intrasectoral collaboration** within the health sector? Does the policy::	2		
(a) Emphasize collaboration with planning, pharmaceutical, human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions,.within the health sector?	2	With respect to the technical coordinating committee	Not broad enough, and more intrasectoral collaboration has to be done

(b) Contain clear statements of what role each department will play in each area for action?	2	The technical committee comes with their expertise	
19. To what extent do the areas for action comprehensively address **intersectoral collaboration?** Does the policy:			
(a) Emphasize collaboration with all other relevant government departments?	1	Virtually all of them	
(b) Emphasize collaboration with all relevant NGOs, including consumer and family groups?	1	It mentions collaboration with NGOs	
(c) Contain clear statements of what role each sector will play in each area for action?	2	Not adequately defined.	
20. Have all of the following groups been considered:			
-- People with severe mental disorders?	1	Talks about substance abuse have been teased out on its own. Its implicit	More attention needs to be paid to specific disorders as done for substance abuse
-- Children and adolescents?	1	Children's issues are dealt with	
-- Older persons?	1	This has been included	
-- People with intellectual disability?	1	Included	
-- People with substance dependence?	1	The one that has been singled out for elaborate discussion	
-- People with common mental disorders?	1	Included	
-- People affected by trauma?	2		
21. Given resources available in the country, has a reasonable balance been achieved between the above groups?	2	In section 50 – 53 of the draft law, all the groups are specified. In current practice however, they are lumped together as one. And implicitly some balance of allocation of resources and time is provided. However there is no way to ensure this.	
22. To what degree have the key mental health policy issues been integrated with/or are consistent with the country's:			

-- Mental health law?	1	The Director of Policy Planning Monitoring and Evaluation and the Chief Medical Officer were involved in the drafting of the policy	
-- General health law?	1	The Director of Policy Planning Monitoring and Evaluation was involved in the drafting of the policy	
-- Patients rights charter?	1	Human rights based	
-- Disability law?	1	Very consistent with it	
-- Health policy?	1	Very consistent as stated in the vision, and is linked up with the country's vision of attaining middle income status	
-- Social welfare policy?	1	Social welfare is involved in facilitating treatment in the general hospitals by certifying as a patient with mental illness. Are a liaison for patients in the general health system	
-- Poverty reduction policy?	2	By virtue of mental health treatment being free	Collaborate more with the relevant agencies
-- Development policy?	3	Very little collaboration	

Taking into account the financial and human resources available in the country, comment on the general feasibility for implementation of the policy.

Mental health is a priority only on paper. In reality it is very poorly resourced. The policy document is well-formulated. However, since it is the Ministry of Health which has to decide on the priorities, and for now mental health is not one of the priorities. For this reason the resources required for the implementation of mental health services are very limited.

There is a lot of lip service in terms of commitment to implement the mental health strategies and plans. Mental health appears too expensive for the policy makers to implement

CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN.

Introduction

Once a Plan/draft plan has been drawn up in a country, it is important to conduct an assessment of whether certain processes have been followed that could lead to the success of the plan, and whether various content issues have been addressed and appropriate actions included in the plan. This checklist is intended to assist with this.

While the checklist is limited in that it does not enable assessment of the *quality* of the processes or contents of the plan, evaluators are encouraged, when completing it, to consider the *adequacy* of both the process and content. Particularly where a response is "no" or "to some extent", it is suggested that they provide either an action plan to remedy the situation or a comment.. (In some instances the comment may, for example, merely be that a particular action is covered elsewhere, or that it is not possible to implement given the current resources available). The different modules in the WHO *Mental Health Policy and Service Guidance Package* can be consulted for more guidance on how to address relevant sections and for a better understanding of the issues mentioned in the checklist.

This checklist may usefully be completed by those who drafted the plan and/or by employees in the government itself. However, it is also important to have *independent reviewers.* Those involved in drawing up the plan may have personal or political interests or may be "too close" to the plan to see anomalies or provide critical input. Ideally, therefore, an independent multidisciplinary team should be convened to conduct an evaluation. A team is also advantageous as no single person is likely to have all the relevant information required, and debate is crucial for arriving at an optimal plan for the country. Furthermore, when relevant interest groups have been involved in the process of the development of the plan and/or in their evaluation, which leads to changes being made to the plan, it is likely that they will be more effectively implemented. It would be useful to include consumer organizations, family organizations, service providers, professional organizations and NGOs, as well as representatives of other government departments affected by the mental health plan.

Finally, although the checklist should be "scored" in terms of the document which outlines the mental health plan, it is important to have, or be familiar with, other relevant and related documentation. Often items are not covered in the plan because they are comprehensively covered elsewhere. For example, plans for health information systems or human resources may include mental health and are therefore deliberately not repeated in the mental health plan. This explanation should then be noted in the relevant section.

CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN

Please use the following rating scale to rate each item: 1 = yes/to a great degree 3 = no/not at all 2 = to some extent 4 = unknown	Rating	If "yes" or "to some extent" please state how. If not, please state reason(s).	Action required (if any)
PROCESS ISSUES			
1a. Was there a high-level mandate to develop the plan (e.g. from the Minister of Health)?	1	**Policy Planning Monitoring and Evaluation Divisio of the Ministryof Health was involved. The Director-General of the Ministry of Health, the Chief Psychiatrist and a representative of the Deputy Director of Nursing Services also attended**	
1b. At what level has the plan been officially approved and adopted? (e.g., the department of mental health, Ministry of Health, Cabinet, Minister of Health)	1	**Approval was at the level of the Minister of Health**	
2. Does the plan include strategies and activities that are consistent with an existing and up-to-date policy?	1	The plan took most of the provisions of the policy into consideration	
3. If no policy is available, does the plan include strategies and activities that are consistent with another official document(s) stating the direction(s) for mental health? Please provide relevant document(s).	1	**Consistent with mental health law (draft)**	
4. Are strategies and activities written in a way that commits the governments (e.g. do they state "will" instead of "should")?	2?	**The style was different**	
5. Has the plan been informed by:			
-- a situation analysis? and/or	2	**No thorough situation analysis was made**	
-- a needs assessment?	1	**The policy was mainly driven by needs assessment**	
6. Have effective strategies that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where necessary?	2	**There was some limited consultation with Nigeria. Nigeria seems to have subsequently adopted some of the policy provisions of Ghana**	

7a. Has a thorough consultation process taken place with the following groups?			
-- Representatives from the health sector, for example, including planning, pharmaceutical, human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions?	2	**Planning officerof the Min of Health, Directors of the Psychiatric hospitals, in consultation with the ministry**	Better intersectoral collaboration.
-- Representatives from the Finance Ministry?	3	People were working independently. Policy drawn up in a hurry. No budget for the policy process	**Strategic sectors should be involved adequately in future planning processes to ease the eventual implementation processe**
-- Representatives from the Social Welfare and Housing Ministry?	3	**Ditto**	**dito**
-- Representatives from the criminal justice system?	3	**Ditto**	**dito**
-- Consumers or their representatives?	3	Ditto	**dito**
-- Family members or their representatives?	3	Ditto	**Ditto**
-- Other NGOs?	1	Basic Needs was extensively involved	
-- Private sector?	3		
-- Any other key stakeholder groups? If so, please list them.	1	**WHO, Royal Netherlands Embassy were involved**	

OPERATIONAL ISSUES

8. Have comprehensive strategies been identified for each priority area for action?	1		
Looking at strategies:			
9. *Time frames:*	1	**Timeframes are allocated to each of the strategies**	
-- Are time frames provided for each strategy?			
-- If so, are the time frames reasonable and feasible?	2	**Reasonable but not feasible due to poor resource allocation and meagre resources not coming in time**	
10. *Indicators:*			
-- Are there indicators for each strategy?	1	Yes they were specified in the plan	

-- If so, are the indicators appropriate for measuring the particular strategy?	1	They were appropriate if the necessary resources were available	
11. *Targets*:			
-- Are there targets for each strategy?	1	Targets were set	
-- If so, are the targets realistic?	1	Yes, realistic if resources are available	
Looking at activities:	1		
12. Are clear activities defined for each strategy?	1	**Yes in the appendix of the prog of work**	
13. Is the person/group/organization responsible for each activity identified?	1	People were made responsible for specific activities	
14. Is it clear when each activity will start and finish?	1	Time frames have been clearly indicated	
15. Are the outputs for each activity outlined?	1	Outputs and deliverables have also been indicated	
16. Have potential obstacles been identified?	2	General obstacles identified but specific obstacles have not been identified in the document	There is the need for an assessment of potential obstacles and strategies to deal with them when they arise
17. Costs and funding:			
-- Have the costs for achieving each activity been calculated?	1	Detailed budget in the appendix of the plan	
-- Is the funding for each activity available and allocated?	3	**Very limited resource allocation**	The budget should be beefed up as a matter of priority
CONTENT ISSUES			
18. Does the plan include relevant strategies and activities for **coordination & management?**			
(a) Are the composition and functions clearly defined for:			
-- The mental health coordinating body?	1	Yes, both in the plan and the draft law	
-- The mental health focal point?	1	Ditto	
(b) Is an adequate infrastructure in place/planned (including computers, Internet access and administrative support)?	2	The plans are there but the structures are currently not in existence	**Pass and implementation of the draft mental health law and improved allocation of resources**

			would be the way out
(c) Are regular meetings of the coordinating body scheduled?	**1**	The law stipulates regular meetings	
(d) Has a system of reporting to a high-level MoH official been set up for the mental health coordinating body?	**1**	In the draft law	
(e) Are coordination and management strategies and associated activities:			
-- Relevant?	**1**	In tune with the policy and draft law	
-- Evidence-based?	**2**	**Not much research apart from quality assurance studies in the hospitals**	Evidence from research in Ghana and elsewhere, as well as from the grey literature (student thesis and dissertations), should be used as part of evidence
-- Realistic and possible to implement?	2	Resource constraints make the realisation of these strategies difficult to achieve in practice	
-- Adequately funded?	2	Limited funding was provided	
19. Does the plan include relevant strategies and activities for **financing?**			
(a) Is it clear how services will be funded?	2	Talked of funding but the plan did not specify sources	
(b) Is the plan clear as to whether/how user charges will be made?	**2**	Not specific on user charges	
(c) Are financing strategies and associated activities			
-- Relevant?	**2**	Strategies for financing were not adequately spelt out	
-- Evidence-based?	**2**	Not much evidence.	
-- Realistic and possible to implement?	**2**	Realistic subject to resource allocation	
-- Adequately funded?	**2**	**Not at all**	
20. Does the plan include relevant strategies and activities for **legislation and/or regulations on human rights?**	**1**	Strategies are specified	
(a) Where legislation and/or regulations are to be developed, have clear strategies/activities been specified for:			

-- the process of drafting the law(s)/regulations?	**2**	**Specified in some detail**	
-- defining the content of the law(s)/regulations?	**2**	**Specified in some detail**	
-- implementing the law(s)/regulations?	**1**	**We have structures and strategies have been spelt out in the law to ensure compliance once it is passed.**	
(b) Where a review body to protect human rights is to be established, are clear strategies/activities specified for its establishment?	**1**	**The review board has activities clarified**	
(c) Are there any other strategies to protect and promote the rights of people with mental disorders?	**1**	**The plan has severaql sections dealing with the rights of users**	
(d) Are the strategies on human rights and legislation and associated activities :			
-- Relevant?	1	**Relevant in terms of current medical practice**	
-- Evidence-based?	2	**Not much scientific evidence. Some empirical evidence is available**	
-- Realistic and possible to implement?	1	**Yes, given commitment and resources**	
-- Adequately funded?	2	**Not at all**	
21. Does the plan include relevant strategies and activities for **organization of services?**			
(a) Are there strategies and associated activities for the provision of services at primary, secondary and tertiary levels, with continuity between them?	1	These are specified in the plan and the policy	
(b) Are there strategies and associated activities for deinstitutionalization?	1	Yes the plan and the draft law stress the importance o community psychiatric services as a way of deinstitutionalisation	
(c) Are there strategies and associated activities for developing community mental health services?1	1	Yes, these are stressed in an effort to deinstitutionalise psychiatric services	
(d) Has provision been made for psychosocial rehabilitation services at all levels of the health system?	2	Not much of this has been specified in the plan, but it is very elaborate in the draft law	
(e) Are the strategies on organization of services and associated activities:	1	Yes subject to availability of resources	
-- Relevant?	1	Relevant to current medical practice	

-- Evidence-based?	2	Not much. There is empirical evidence	
-- Realistic and possible to implement?	2	Yes, not too ambitious	
-- Adequately funded?	2	Not at all	
22. Does the plan include relevant strategies and activities for **promotion, prevention and rehabilitation?**	1	Yes, these are mentioned both in the plan and in the draft law	
(a) Are there clear strategies and associated activities for the promotion of mental health?	1	Yes, the bill specifies it	
(b) Are there clear strategies and associated activities for the prevention of mental disorders?	2	Talks of educational programmes in selected institutions for prevention	
(c) Are the strategies on prevention, promotion and rehabilitation and associated activities			
-- Relevant?	1	They are very relevant in terms of moving from curative to preventive medicine	
-- Evidence-based	2	No empirical researched done yet	Need for research
-- Realistic and possible to implement?	2	Not sure of adequate funding and logistics	
-- Adequately funded?	2	Not adequate currently	
23. Does the plan include relevant strategies and activities for the **procurement and distribution of essential medicines**?	1	Quite elaborate on that	
(a) If psychotropic medicines currently are not included on the Essential Drugs List is there a strategy and associated activities to include them?	NA	In Ghana, some psychotropic medicines are part of the drug list	Broaden the list of medications for mental illness
(b) Does the plan incorporate strategies and associated activities to improve reliability of the supply and distribution system at relevant levels of health service where treatment is provided?	3	No structures have been specified	To incorporate into the plan
(c) Are there strategies and relevant activities for monitoring the continuous provision and assessment of psychotropic medicines?	2	The provisions are there, in the form of feedback from CPNs but they are not adequate	A more elaborate strategy id requiured
(d) Are the strategies on the procurement and distribution of medicines and associated activities:			
-- Relevant?	2	Did not make it very elaborate	More elaborate strategies should be

			developed
-- Evidence-based?	2	Empirical knowledge and research from other parts of the world	"
-- Realistic and possible to implement?	2	Did not forsee some of the bottlenecks	"
-- Adequately funded?	2	Not much funding	"
24. Does the plan include relevant strategies and activities for **advocacy?**	1		
(a) Is there a strategy with associated activities to support (technically and/or in practical terms) consumer groups, family groups and NGOs?	3	Listed in the Law but not the plan	
(b) Is there a strategy and associated activities to involve consumers and family representatives in policy and service planning?	1	It is in the draft law	To lobby for passing the law
(c) Are the advocacy strategy and associated activities:			
-- Relevant?	1		
-- Evidence-based?	2		
-- Realistic and possible to implement?	1		
-- Adequately funded?	2		
25. Does the plan include relevant strategies and activities for **quality improvement?**	1		
(a) Is there a strategy and associated activities for assessing quality?	1	There are quality control elements enshrined in the bill and the plan.	
(b) Is there a strategy and associated activities for ongoing quality control of mental health facilities (e.g. standards)?	1		
(c) Is there a strategy and associated activities for accrediting facilities based on quality?	1		
(d) Are both hospital and community mental health facilities included in quality assessment?	1		
(e) Are the strategies on quality improvement and associated activities:	1		
-- Relevant?	1		
-- Evidence-based?	2		

-- Realistic and possible to implement?			
-- Adequately funded?	2		
26. Does the plan include relevant strategies and activities for **information systems?**	2	Info system has not been well-defined	Better structures need to be put into the policy
(a) Have a strategy and linked activities been defined for:			
-- Reviewing the current mental health information system, and/or	2		
-- Improving the current mental health information system?	2		
(b) Does the strategy or linked activities include the systematic collection of mental health data from a range of sources at different levels of the health system (e.g. from general hospitals, primary health care and community levels)?	2		
(c) Is it clear how the information will feed back into:			
-- Policy development, mental health planning and service delivery?	2		
-- Clinical practice?	2		
(d) Are the strategies on information systems and associated activities:			
-- Relevant?	2		
-- Evidence-based?	2		
-- Realistic and possible to implement?	2		
-- Adequately funded?	2		
27. Does the plan include relevant strategies and activities for **human resources development and training?**	1		
(a) Is there a well-defined strategy with associated activities for assessing available personnel and competencies at different service levels?	1		
(b) Is there a strategy to improve the number of providers for mental health?	1		
(c) Are there relevant management strategies and activities to address:			
-- Recruitment?	1		
-- Retention?	1		

-- Deployment of staff?	1		
(d) Has provision been made for ongoing education, training and skills development?	2		Urge compliance with the plan
(e) Is there a strategy/relevant defined activities to introduce changes to undergraduate and graduate curricula of health and allied health workers?	1	At the community psychiatry training level, medical assistants medical offfocers etc	
(f) Is there a strategy for training health providers to develop the appropriate competencies at the levels of :			
-- Informal community services?	1	1community based volunteers, nations for mental health	
-- Primary health care services?	1	Present providers in the system and the general hospital care, eg, nurses	
-- General hospital care?	1	Same as above	
-- Specialist care?	1	local post graduate trg programme	
(g) Are the strategies on human resources and associated activities :			
-- Relevant?	1		
-- Evidence-based?	2		
-- Realistic and possible to implement?	2		
-- Adequately funded?	2		
28. Does the plan include relevant strategies and activities for **research and evaluation**?			
(a) Are there strategies for improving capacity to conduct research and evaluation?	2		
(b) Will the research address practical issues for the country?	1		
(c) Has provision been made to evaluate the policy and plan?	1		
(d) Are research and evaluation strategies and defined activities:			
-- Relevant?	1		
-- Evidence-based	2		
-- Realistic and possible to implement?	2		

-- Adequately funded?	2		
29. Does the plan include relevent strategies and activities for **intrasectoral collaboration?**			
(a) Is a structure planned/in place through which intrasectoral collaboration could take place with the following departments within the health sector	2	There is no formal structure but there are informal collaborations.	Put in place a formal structure
(b) Is collaboration with the following departments within the health sector included in the plan:	2		
- Planning?	2	PPME was part of the planning process, but no system of on-going collaboration	Put in place a formal system.
- Pharmaceutical?	2		
- Human resource development?	2		
- Child health?	3		
- HIV/AIDs?	2	There are HIV counsellors within the mental health system, and they collaborate with the HIV unit at Adabraka polyclinic.	
- Epidemiology and surveillance?	3	No collaboration so far	Need to systmtize on a regular basis
- Epidemic and disaster preparedness divisions?	3	As above	
30. Does the plan include relevant strategies and activities for **intersectoral collaboration**?	1		
(a) Is there a structure planned/in place through which intersectoral collaboration could take place?	1		
(b) Is collaboration with the following government departments included in the plan?	1		
-- Social services	1		
-- Justice	1		
-- Education	1		
-- Housing	2	As part of provisions of rehabilitation, housing has not been mentioned.	

-- Corrections	1		
-- Police	1		
(c) Is collaboration with the following groups included in the plan?	1		
-- NGOs	1		
-- Consumer groups	1		
-- Family groups	1		.
(d) Have the following groups been considered?			
-- People with severe mental disorders?	1		
-- Children and adolescents?	1		
-- Older persons?	1		
-- People with intellectual disabilities?	1		
-- People with substance dependence?	1		
-- People with common mental disorders?	1		
-- People affected by trauma?	2	Treated as other mental disorders are.	
(e) Given financial and human resources available in the country, has a reasonable balance been achieved between the above groups?	2	In practice, resource allocation is unlikely to be increased, hence the 2.	
(f) Overall, are the strategies on intersectoral collaboration and associated activities :			
-- Relevant?	1		
-- Evidence-based?	2	Research not conducted.	
-- Realistic and possible to implement?	2	Not sure of adequate funding in the near future	
-- Adequately funded?	2	Commitment not exhibited yet.	
31. To what degree have the key mental health strategies been integrated into the country's existing strategic plans for::			
-- Improving patients' rights?	2	Old law did not mention this and the current bill is yet to be passed.	

-- Improving rights for people living with disabilities?	1		
-- Overall health?	1		
-- Social welfare?	2	We do not have cash supplements for our patients, half way homes or social welfare systems, ie, no affirmative action nor job quotas.	
-- Poverty reduction?	3	No jobs set aside for the various levels of disability,, no structures to ensure financial support	
-- Development?	2	Mental health mentioned as part of the disability bill.	The Social Vulnerability Bill could include some support for people with mental illness

32. Taken into account the financial and human resources available in the country, comment on the general feasibility for implementation of the policy.

If the draft law is passed it would be possible to impleemnet to a large extent. With improved resource allocation and human resourcit is feasible to implement the policy in the medium and long term

7.3 Appendix 3: Sample of SSI and FGD Instruments

7.3.1 Sample of SSI guide for Programme Directors - Macro Level

Preliminaries:

- *Check that you have considered focal points of interview in relation to the research objectives*
- *Did respondent receive background document on research (letter and flier)? (Take additional copies)*
- *Clarify research and meaning of policy*
- *Explain confidentiality and no attribution*
- *Get agreement on taping*
- *Clarify time available for interview*
- *Ask for copy of any relevant documents such as annual reports, policies or plans*
- *Include relevant extra questions or probes based on information received to date from other informants or background documents*

*1.1 You do not need to ask all probes for all questions. Use probes to get more information where the respondent is not answering fully or freely, if the respondent doesn't appear to understand the question (they can be used as examples) and to follow up interesting points. **Use your judgement.***

1.2 In particular, think about the position level of your respondent. At district level, ask respondents what <u>does</u> happen. If the respondent is in a senior management/policy position, ask the respondent about what does happen in practice, and what <u>should</u> happen i.e., what the mental health policy is.

1.3 Ask the respondents to briefly introduce themselves, what their experience is, how long they have been in this post.

Question route:

	QUESTION	PROBES
A. GENERAL CONTEXT		
1.	Any external trends which are important for/influencing the country public sector?	*international, regional*
2.	What do you think is the overall level of foreign support for health and health care?	*including position of mental health*
3.	What is the position of mental health within the social, development and health priorities of the country?	*e.g. funding patterns; media coverage; mutual links with poverty*
4.	What are the key health problems in your country?	*including key mental health problems*

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		QUESTION	PROBES
5.		What are the government policies outside the health sector, which have an influence on mental health?	*e.g. education, social welfare, prisons, women affairs etc*
6.		What is the extent to which mental health is related to policies on other priority health conditions/programmes?	
B. GENERAL SITUATION REGARDING MENTAL HEALTH			
7.		Can you describe a person who is mentally healthy?	*how would that person look / behave / interact with others*
8.		Can you describe a person who is mentally unhealthy?	*how would that person look / behave / interact with others*
9.		Who and how assesses mental health needs at all levels?	*how appropriate are the methods?*
C. POLICY MAKING PROCESS WITHIN THE PUBLIC SECTOR			
10.		Do any values underpin general policy-making process in the country?	*equity, solidarity, poverty alleviation, religion*
11.		Can you describe the processes of policy-making in the country?	*participatory nature, use of evidence, consistency, etc; include different stages ie development, formulation, implementation*
D. DEVELOPMENT OF MENTAL HEALTH POLICIES AND MENTAL HEALTH LAWS			
12.		Where do you think is the locus/i of mental health policy making in government compared to other social policies?	
13.		Is mental health policy assessed? If so, who, how and how often assesses mental health policy?	*include different stages & processes involved*
14.		Is the mental health policy process different from policy processes in other health programmes? If so, how?	*stages of the process (development, formulation); use of evidence; degree of integration, etc*
15.		Do any values underpin the policy development process? If so, which?	*eg. equity, solidarity; any differences at stages of policy development and implementation?*
16.		Are there any mental health needs assessment processes that inform mental health policy? Do you think these are appropriate?	*who does this and how often*
17.		What are the priority-setting practices within mental health policy?	*who and how sets priorities; how participatory is the process*

		QUESTION	PROBES
E. STAKEHOLDERS AND THEIR INFLUENCE ON THE FORMULATION OF MENTAL HEALTH POLICIES AND MENTAL HEALTH LAW			
18.		Who are the key individuals and/or organisations involved in setting country Laws and policies? How are they involved?	*internal and external; under-represented; from and outside MOH; prompt for religious leaders, users, govt bodies etc include direct and indirect influences*
19.		Is there someone (individual or organisation) who is not but should be involved in setting Laws and policies? What are the reasons (barriers) and how the situation can be improved?	
20.		How are key individuals and organisations (stakeholders) across different sectors involved in mental health policy and law development? Any differences across sectors / groups?	*including implementation; prompt for any practices, tools and processes; at what level they interact*
21.		Describe any barriers to this involvement some groups and how this can be improved?	*Inluding issues of capacity*
22.		Who are the key stakeholders in the health sector and how they influence mental health policy development and implementation?	*Any mental health policy networks and communities? How do they operate?*
23.		Who is under-represented but should be and why?	
24.		Describe any barriers to involvement of some groups and how this can be improved?	*Including recognition by other actors and capacity any actions from their side?*
F. APPROPRIATENESS OF THE RESULTANT MENTAL HEALTH POLICIES AND MENTAL HEALTH LAW			
25.		Whether and how evidence is used in mental health policies?	*if so, what types of evidence (research results, experience, users' views, service providers' opinions)? are policies based on needs?*
26.		What mental health issues do you feel are not accommodated in health policies? Why do you think they are not? How the situation can be improved?	
27.		Do the mental health policies address wider societal issues?	*poverty, stigma etc elaborate on example of e.g. anti-stigma initiatives*

	QUESTION	PROBES
28.	How integrated is mental health policy in general health and in wider societal policies?	*including degree of multisectoralism* *How the situation can be improved?*
29.	Does the existing mental health policy and Law require development/reform?	*if so, what actions are required?*
G. TRANSLATION OF NATIONAL LEVEL MENTAL HEALTH POLICIES AND MENTAL LAW INTO STRATEGIC PLANS		
30.	Are there any barriers and facilitating factors for implementing MH Law and how situation can be improved?	
31.	What barriers and facilitating factors exist to implementation of national mental health plans?	*resource constraints;* *other programmes' pressures;* *political commitment;* *health sector management framework;* *technical capacity;*
32.	How mental health services are provided at national level?	*description of service delivery including levels of care;* *institutional arrangements;* *information system for monitoring and evaluation;*
33.	What are the current financial resources available for mental health nationally?	*including how they are distributed, what processes/criteria used for decision-making, who makes decisions;* *integration of MH financing flows into wider health/non-health budget*
34.	Describe the private sector and its role in mental health care?	*including NGOs*
35.	Describe the traditional healers and their role in mental health care?	
H. ADAPTATION AND IMPLEMENTATION OF NATIONAL LEVEL MENTAL HEALTH POLICIES BY REGIONAL/PROVINCIAL STRUCTURES		
36.	What barriers and facilitating factors exist in implementing policies and plans at the regional level?	*how the situation can be improved?*
37.	What management frameworks are in place to support implementation of MH policies and plans at regional/ provincial level? Are those effective?	*if not effective, what are the ways to improve?*

	QUESTION	PROBES
38.	What is the financing mechanism to mental health at provincial/regional level?	*if problems how to improve?*
39.	What support systems are in place at regional level to ensure implementation of MH policies and plans?	*description and analysis of: HMIS, quality assurance, compulsory treatment, etc*
40.	What is the human resource capacity for mental health care at the provincial/regional level across the sectors?	*numbers across categories of staff, distribution, integration with other services/sectors, etc*
41.	What are the training & capacity building needs of MH managers and service providers at provincial/regional level?	*both within and outside health sector*

SNOWBALLING

a) Are there any other comments you would like to make about the mental health policies, and in particular, the role of different actors in the process?

b) Do you have any reports or documents that we might find useful for this research e.g. Any statements of policy and objectives, annual reports and so on?

c) Do you know of any meetings or other events in the near future that you think would be useful for us to attend?

"Thank you for your time. As I said earlier, this information will be treated confidentially, and we will be providing you with a report on the research once it is complete. We may come back to you for further information if necessary; I hope that will be alright."

7.3.2 Sample of SSI guide for Head of Nursing Institution - Meso level

Preliminaries:

- *Check that you have considered focal points of interview in relation to the research objectives*
- *Did respondent receive background document on research (letter and flier)? (Take additional copies)*
- *Clarify research and meaning of policy*
- *Explain confidentiality and no attribution*
- *Get agreement on taping*
- *Clarify time available for interview*
- *Ask for copy of any relevant documents such as annual reports, policies or plans*
- *Include relevant extra questions or probes based on information received to date from other informants or background documents*

1.4   You do not need to ask all probes for all questions. Use probes to get more information where the respondent is not answering fully or freely, if the respondent doesn't appear to understand the question (they can be used as examples) and to follow up interesting points. **Use your judgement.**

1.5   In particular, think about the position level of your respondent. At district level, ask respondents what <u>does</u> happen.   If the respondent is in a senior management/policy position, ask the respondent about what does happen in practice, and what <u>should</u> happen i.e., what the mental health policy is.
1.6
1.7   Ask the respondents to briefly introduce themselves, what their experience is, how long they have been in this post.

Question route:

	QUESTION	KEY NOTES
	GENERAL CONTEXT	
1.	What is the position of mental health within the social, development and health priorities of the country? (PROBES: *e.g. funding patterns; media coverage; mutual links with poverty)*	
	POLICY MAKING PROCESS WITHIN THE PUBLIC SECTOR	
2.	Can you describe the processes of policy-making in the country? (PROBES: *participatory nature, use of evidence, consistency, etc; include different stages ie development, formulation, implementation)*	
	DEVELOPMENT OF MENTAL HEALTH POLICIES AND MENTAL HEALTH LAWS	

		QUESTION	KEY NOTES
3.		Where do you think is the locus/i of mental health policy making in government compared to other social policies?	
4.		Do any values underpin the policy development process? If so, which? (PROBES: *eg. equity, solidarity;* *any differences at stages of policy development and implementation?*)	
5.		Are there any mental health needs assessment processes that inform mental health policy? Do you think these are appropriate? (PROBES: *who does this and how often*)	
6.		What are the priority-setting practices within mental health policy? (PROBES: *who and how sets priorities;* *how participatory is the process*)	
		STAKEHOLDERS AND THEIR INFLUENCE ON THE FORMULATION OF MENTAL HEALTH POLICIES AND MENTAL HEALTH LAW	
7.		Who are the key stakeholders in the health sector and how they influence mental health policy development and implementation? (PROBES: *Any mental health policy networks and communities?* *How do they operate?*)	
8.		Who is under-represented but should be and why?	
9.		Describe any barriers to involvement of some groups and how this can be improved? (PROBES: *Including recognition by other actors and capacity* *any actions from their side?*)	
		APPROPRIATENESS OF THE RESULTANT MENTAL HEALTH POLICIES AND MENTAL HEALTH LAW	
10.		Whether and how evidence is used in mental health policies? (PROBES: *if so, what types of evidence (research results, experience, users' views, service providers' opinions)?* *are policies based on needs?*)	
11.		What mental health issues do you feel are not accommodated in health policies? Why do you think they are not? How the situation can be improved?	

	QUESTION	KEY NOTES
12.	Do the mental health policies address wider societal issues? (PROBES: *poverty, stigma etc elaborate on example of e.g. anti-stigma initiatives*)	
13.	How integrated is mental health policy in general health and in wider societal policies? (PROBES: *including degree of multisectoralism How the situation can be improved?*)	
	TRANSLATION OF NATIONAL LEVEL MENTAL HEALTH POLICIES AND MENTAL LAW INTO STRATEGIC PLANS	
14.	Are there any barriers and facilitating factors for implementing MH Law and how situation can be improved?	
15.	What barriers and facilitating factors exist to implementation of national mental health plans? (PROBES: *resource constraints; other programmes' pressures; political commitment; health sector management framework; technical capacity;*)	
16.	How mental health services are provided at national level? (PROBES: *description of service delivery including levels of care; institutional arrangements; information system for monitoring and evaluation;*)	
17.	What are the beliefs and attitudes of mental health care providers towards the mentally ill (including attitudes towards both severe and common mental disorders)? (PROBES: *how do they define mentally healthy vs. ill person?*)	
18.	Describe the private sector and its role in mental health care? (PROBES: *including NGOs*)	
19.	Describe the traditional healers and their role in mental health care?	
	ADAPTATION AND IMPLEMENTATION OF NATIONAL LEVEL MENTAL HEALTH POLICIES BY REGIONAL/PROVINCIAL STRUCTURES	
20.	What barriers and facilitating factors exist in implementing policies and plans at the regional level? (PROBES: *how the situation can be improved?*)	

SNOWBALLING

d) Are there any other comments you would like to make about the mental health

policies, and in particular, the role of different actors in the process?

e)   Do you have any reports or documents that we might find useful for this research e.g. Any statements of policy and objectives, annual reports and so on?

f)   Do you know of any meetings or other events in the near future that you think would be useful for us to attend?

"Thank you for your time. As I said earlier, this information will be treated confidentially, and we will be providing you with a report on the research once it is complete. We may come back to you for further information if necessary; I hope that will be alright."

7.3.3 Sample of SSI guide for Traditional Healers - Micro Level

Before the interview, ensure you are familiar with the interviewer notes.

The phrase "mental problems" has been used throughout this questionnaire but this needs to be changed depending on the country, language and context. This interview requires a great deal of probing to find out more about the issues which come up during the discussion.

Introduction

Thank you for agreeing to take part in this interview. The aim of the discussion is twofold; firstly, for us to develop an understanding of how the mental health needs of people are met by traditional healers, and secondly to find out whether traditional healers would like support and training in caring for persons with mental health problems.

	QUESTION	*Notes/Key words*
1.	**Background**	
a.	How did you become traditional healers?	
b.	What training did you receive? *(probe for length, who it was with, what they learnt)*	
c.	Did you receive any training specifically for mental problems? *(If yes, what kind of training. If no, would you like training?)*	
d.	If someone comes to you for help how do you diagnose what problem they have? *(probe for techniques used and system/categories of diagnosis)*	
e.	Are there specific diagnoses for mental problems? *(If so, what are these?)*	
f.	What are the reasons that someone would suffer from mental problems? (*probe for different explanatory models of illness)*	
g.	Are there special treatments for mental problems? *(If so, what are these? Probe for herbal medicine, rituals, other treatments and support)*	
2.	**The following questions are about the care of people with mental health problems.**	
a.	How many people do you see a month who have mental problems?	

	QUESTION	Notes/Key words
b.	How do people with mental problems come to use your services *(own choice, family members, referrals from other traditional healers, PHC clinics)*	
c.	If you could not help them, where might you refer them to? *(Probe for what problems they feel they cannot treat and where they refer them e.g., other traditional healer, PHC clinic, hospital, community health worker)*	
d.	What support mechanisms are in place currently to assist you in caring for people with mental health problems? Describe these. *(If limited or none, what other support do you need?)*	
e.	If people have been through hard times such as rape or the death of a loved one, would they come to traditional healers for help? *(If yes, what help or support would you provide?)*	
f.	Do any of you belong to the Traditional Healers Organisation or any other organisations? *(If yes, do these organisations ever discuss mental issues?)*	
g.	How often do you interact with medical practitioners such as a primary health care or psychiatric nurse? *(What form does this interaction take? How happy are you with this interaction? Can this be improved?)*	
h.	Are you aware of what can happen if a person uses both herbal medicine and medicine from a doctor at the same time? *(If yes, probe for knowledge of effects of drug interactions?)*	
i.	Do you think that traditional medicine and the medical system can work together? *(If yes, how can this be achieved? Probe for how they think the formal health system could support them in their work)*	
j.	Aside from your training as traditional healers, have you ever had any other health training? *(If yes, what kind of training, if no, would you like any training?)*	

	QUESTION	Notes/Key words
k.	Do you have any formal links to the health system e.g., referral networks? (*If yes, what kind of links, if no, would you like to have some kind of link*?)	
l.	Do you think that there are any links between poverty and mental problems? (*If yes, describe these links. What could be done to eradicate these links?*)	
m.	Do you think that there are any links between gender and mental problems? *(If yes, describe these links. What could be done to deal with these links?)*	
3.	**The following questions are about the care of children and adolescents with mental problems.**	
a.	Do you see children or adolescents who need help with mental problems?	
b.	If yes, do they have the same problems as adults or different ones?	
c.	If yes, would they have the same treatments as adults or different ones?	
d.	If yes, if you could not help a child or adolescent with their mental problems where would you refer them to? *(Probe for what problems they feel they cannot treat and where they refer them e.g., other traditional healer, PHC clinic, hospital, community health worker)*	
4.	**The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans).** *This must be tailored for each country*	
a.	Have you heard about the new Mental Health Care Act, no 17 of 2002? (If yes, have you received any training in the provisions of the Act? What are your feelings about the Act)	
5.	**General**	
a.	Are there any other comments you would like to make regarding mental health care?	

SSI Summary Sheet

Administrative information

Interviewer
Participant number
Date of interview
Sex of respondent
Country
Province/Region
District
Urban or rural district
Consent procedure completed?
Start and end time of interview

Interviewer notes

File numbers used on IC recorder:
Voice Editor Storage   File Name:
                                              Date Loaded:

Back up Storage: Interview backed up   Backup location:
before deleting from IC recorder?
Tracking sheet completed for this
interview?
Observations:
Sketch an overview of the interview: Will this interview contribute to the analysis (*Guide: Good rapport, open participant, rich and spontaneous responses, good follow up possible with probes, views of participant clearly expressed and verified by interviewer or?*)
Were there any ideas which emerged from this interview which can contribute to our thinking? (*Guide: new, contradictory, confirming ideas, trends). What hypotheses/trends emerged from this interview?*)
Any other observations?

7.3.4 Sample of FGD guide for Teachers – Micro level

Before the focus group, ensure you are familiar with the interviewer notes.
Introduction

Thank you for agreeing to take part in this focus group. The aim of the discussion is twofold; firstly, for us to develop an understanding of how the mental health needs of learners are met within the school system, and secondly to find out whether teachers need training in dealing with child and adolescent mental health issues.

	QUESTION	*Notes/Key words*
6. Background		
h.	How do you view mental illness?	
i.	What role do you play in caring for learners with mental health or behavioural problems?	
The following questions are about the care, treatment and rehabilitation of children and adolescents with mental and behavioural problems within the school system.		
b.	How long has each of you been teaching?	
c.	What level do you teach at? (age/grade)	
d.	Have any of you had an experience of teaching a learner with mental or behavioural issues? These can range from learning difficulties, being the victim of abuse, substance abuse, anorexia, depression, anxiety.	
e.	What was that experience like for you? What was the hardest part of that experience? Did you feel able to cope with the learner? Please be honest, we are trying to find out if teachers need training and support for these situations.	
f.	What did you do? *(probe for counseling, referral, reporting, calling in parents, or just ignoring the problem)*	

	QUESTION	Notes/Key words
g.	What do you feel are the biggest mental health challenges faced by learners? *(probe for behavioural problems, sexual abuse, learning disabilities).*	
h.	Have you been trained to identify, counsel and refer children/adolescents with mental and behavioural problems? *(If yes, describe the training in terms of frequency and comprehensiveness. If limited or none, what training needs do you still have?)*	
i.	What support mechanisms are in place currently to assist you in working with children and adolescents with mental health problems? Describe these. *(If limited or none, what other support do you need?)*	
j.	Where do you refer children and adolescents who need specialist psychological help? Are there any special facilities in the district or region for children and adolescents to be referred to e.g. Child and Adolescent Mental Health Unit?	
k.	Are there any programmes for the prevention of specific problems for children e.g., sexual violence, substance abuse, other high risk behaviours? *(Probe number, what they do and who runs these)*	
l.	Are there any specific support programmes for problems commonly experienced by children e.g. for children who are sexually abused, children with learning difficulties, substance abuse problems? *(Probe number, what they do and who runs these)*	
m.	Do you have links with any mental health programmes that are currently being run in the district? Or are you currently running any awareness, educational or training programmes within your district/community?	

	QUESTION	Notes/Key words
n.	If a child/adolescent with mental health problems remains in the school system, what steps are taken to make this easier for the learner, for other learners and for teachers?	

7. The following questions are about socio-economic and cultural factors that play a role in mental health.

a.	Do you think that there are any links between poverty and poor mental health? (*If yes, describe these links. What could be done to eradicate these links?*)	
b.	Do you think that there are any links between gender and poor mental health? (*If yes, describe these links. What could be done to deal with these links?*)	
c.	What do you think are the main reasons people develop mental health problems? (*probe for bio-medical, cultural beliefs, stress*)	

8. The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans). *This must be tailored for each country*

o.	What do you know about the new Mental Health Care Act, no 17 of 2002?	
p.	Have you received training in the provisions of the Act?	
q.	What impact do you feel that the Act has had on your job?	
r.	What impact do you feel that the Act has had on the lives of people with mental health problems?	
s.	Are there any changes needed to the Act?	

	QUESTION	Notes/Key words
t.	Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*Probe for details: How are rights protected, violated? What still needs to be done?*)	
u.	Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?*)	
v.	Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should still be done?*)	
9. General		
b.	Are there any other comments you would like to make regarding mental health care?	

SSI Summary Sheet

Administrative information

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Participant number
Date of interview
Sex of respondent
Country
Province/Region
District
Urban or rural district
Consent procedure completed?
Start and end time of interview

Interviewer notes
File numbers used on IC recorder:
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Back up Storage: Interview backed up   Backup location:
before deleting from IC recorder?

Tracking sheet completed for this
interview?
Observations:
Sketch an overview of the interview: Will this interview contribute to the analysis (*Guide: Good rapport, open participant, rich and spontaneous responses, good follow up possible with probes, views of participant clearly expressed and verified by interviewer or?*)
Were there any ideas which emerged from this interview which can contribute to our thinking? (*Guide: new, contradictory, confirming ideas, trends). What hypotheses/trends emerged from this interview?*)
Any other observations?

7.4 Appendix 4: Coding Framework for Qualitative Data Analysis

7.4.1 Macro/Meso level coding frame

Parent nodes (level 1)	Level 2	Level 3	Level 4 (Suggestions for further children)	Description
Context				Objective A
	Development priorities			Development priorities of the country
	Economic factors			Economic factors affecting the country
		Poverty		Key poverty related issues and poverty alleviation strategies
		Unemployment		Burden of unemployment
		Equity		Equity or inequity in the country
	Political factors			Political factors affecting the country
	Social factors			Social factors in the country
	International factors			International factors affecting the country, e.g. international trends, globalization, policies of international development agencies
	Regional issues			Issues affecting regions of the country e.g. war in a region, regional priorities
	Gender issues			Gender issues in the country
	Health issues			Issues concerning the population's health or the health system
		Population health		The health of the population, e.g. the burden of diseases, trends in disease, epidemiological transition
		Health system		Issues concerning the health system in the country
		Health policies		Key health policies in the country
	Demographic factors			Issues such rural-urban population distribution, population ageing
Mental health				Objective B

situation			
	Respondent's interest in mental health		The respondent's description of their interest in mental health and the reasons for their interest.
	Perception of mental health		Description of people's perceptions of mental health and mental illness. Trends over time.
		Definition of mental health/illness	Definitions and meanings of mental health or mental illness. Trends over time.
		Professional views of mental illness	Views of mental health professional about mental health/illness
		Non professionals views of mental illness	This will include the definitions & views that non mental health workers hold about mental health/illness
		Causes of mental illness	The perceived causes of mental illness. Trends over time.
		Public awareness	Awareness and knowledge of mental health problems among the general public, health professionals, policy makers, other sectors etc.
		Management/treatment of mental illness	The perceived means of treating or managing mental illness. Trends over time.
		Health seeking behaviour	The health seeking behaviour of people with mental illness, e.g. use of public health services, traditional healers. Trends over time.
		Challenges	Challenges or problems regarding perceptions of mental health and mental illness
		Areas of actions	Areas of action, suggestions, recommendations regarding perceptions of mental health and mental illness
	Significance of mental health		The burden of mental health and the prioritisation of mental health
		Prioritisation of mental health	The priority of mental health to the government, international organisations, the media etc.
		Burden of mental illness	The key mental health problems, the prevalence of mental illness, trends in the burden of mental

		illness etc
Priorities within mental health		The key priorities within mental health in the country, e.g. diseases or issues such as forensics, children and adolescence, intellectual disability, trauma and violence, substance abuse
Poverty and mental health		Relationship between mental health and poverty and areas of action
	Relationship between poverty and mental ill-health	Relationships or interactions between mental health and poverty
	Areas of action	Areas of action, suggestions, recommendations regarding poverty and mental health
Stigma		Descriptions of stigma and mental health
	Source of stigma	The sources of stigma in mental health, for example stigmatisation by the government, the family, self.
	Consequences of stigma	Consequences of stigma on individuals, society and policy development and implementation
	Strategies to address stigma	Strategies to address stigma that are in place or suggested
Mental health user organization		The nature of mental health user organization in the country
	Needs for user organization	Stakeholder's viewpoints about the need and strategies for user organization
	Model	Views on different models for user organization
	Funding for organization	Funding opportunities to enable user organizations to function
Challenges		Challenges or problems regarding the mental health situation
Areas of action (general)		Areas of action, suggestions, recommendations regarding mental health and the mental health system

General policy processes				Objective C
				Information about the policy process in general, including health policy or other public sectors' policy processes.
	Policy stakeholders			The key stakeholders/actors involved in policy making in general and their role in the process.
	Policy development process/stages			The processes and stages used in policy development. May include initiation of ideas, drafting policy, consultation with stakeholders etc.
		Initiation		Initiation of policy ideas
		Development		Development of policy
		Consultation		Consultation with stakeholders during policy development
	Use of information			The use of information or evidence in policy development in general. May include research, HMIS, media reports etc.
	Policy implementation			Implementation of policies in general.
	Challenges			Challenges in the policy development in general
	Areas of action			Areas of action, suggestions, recommendations policy development in general
MH Policy and law development				Objectives D and E
	MH Policy development			Issues concerning development of the mental health policy.
		Process/stages		The processes/stages used in mental health policy development. May include initiation of ideas, drafting policy, consultation with stakeholders etc.
			Initiation	Initiation of policy ideas
			Development	Development of policy
			Consultation	Consultation with stakeholders during policy development
		Factors influencing		The key factors that influence the mental health policy

			development process.
	Stakeholders		The key stakeholders/actors involved in mental health policy development, their role and barriers to their involvement.
		Users	Barriers and opportunities for involvement with policy development specific to users
		Other stakeholders	Barriers and opportunities for involvement with policy development for other stakeholders
	Use of information		The use of information or evidence in mental health policy development. May include research, HMIS, media reports etc.
	Strengths		Strengths of mental health policy development
	Challenges		Challenges in mental health policy development
	Areas of action		Areas of action, suggestions, recommendations or strategies to improve mental health policy development
MH Law development			Issues concerning development of the mental health law
	Process/stages		The processes/stages used in mental health law development. May include initiation of ideas, drafting law, consultation with stakeholders etc.
		Initiation	Initiation of policy ideas
		Development	Development of policy
		Consultation	Consultation with stakeholders during law development
	Factors influencing		The key factors that influence the mental health law development process.
	Stakeholders		The key stakeholders/actors involved in mental health law development, their role and barriers to their involvement.
		Users	Barriers and opportunities for involvement with law development specific to users
		Other stakeholders	Barriers and opportunities for involvement with law development for other

		Use of information		The use of information or evidence in mental health law development. May include research, HMIS, media reports etc. Information on quality and what is reported in HMIS.
		Challenges		Challenges in mental health law development
		Areas of action		Areas of action, suggestions, recommendations or strategies to improve mental health law development
MH Policy and law content				Objective F
	Mental health Policy			Mental health policy content
		Appropriateness of policy		Appropriateness of mental health policy, including description of gaps in policy
			Prevention/ promotion	Appropriateness of mental health policy regarding prevention or promotion of mental health
			Treatment	Appropriateness of mental health policy regarding treatment for mental illness
			Support/rehabilitation	Appropriateness of mental health policy regarding support or rehabilitation for mental illness
			Integration/separation	Appropriateness of mental health policy regarding integration of mental health with primary care or separation/institutionalisation of mental health services.
			Gender issues	Appropriateness of mental health policy regarding gender issues
			Child and adolescent issues	Appropriateness of mental health policy regarding children and adolescents
			Poverty	Appropriateness of mental health policy regarding poverty
			Disability	Appropriateness of mental health policy regarding disability
			Human rights	Appropriateness of mental health policy regarding human rights
			Feasibility	Feasibility of mental health policy
			Financing	Appropriateness of financing

			mechanisms in policy, e.g. payment requirements for mental health patients
		Regulation of private sector	Appropriateness of policy regarding regulation of private sector in mental health provision, regulation of the qualification requirement for private providers, the quality of services etc.
	Integration with other policies/laws		Integration or links between mental health policy and the mental health law and other policies and laws
	Areas of action		Areas of action, suggestions, recommendations regarding the mental health policy content
Mental health Law			Mental health law content
	Appropriateness of law		Appropriateness of mental health law, including description of gaps in law
		Prevention/ promotion	Appropriateness of mental health law regarding prevention or promotion of mental health
		Treatment	Appropriateness of mental health law regarding treatment for mental illness
		Support/rehabilitation	Appropriateness of mental health law regarding support or rehabilitation for mental illness
		Integration/separation	Appropriateness of mental health law regarding integration of mental health with primary care or separation/institutionalisation of mental health services.
		Gender issues	Appropriateness of mental health law regarding gender issues
		Child and adolescent issues	Appropriateness of mental health law regarding children and adolescents
		Poverty	Appropriateness of mental health law regarding poverty
		Disability	Appropriateness of mental health law regarding disability
		Human rights	Appropriateness of mental health law regarding human rights
		Feasibility	Feasibility of mental health law
		Financing	Appropriateness of financing mechanisms in law, e.g. payment

			requirements for mental health patients
		Regulation of private sector	Appropriateness of law regarding regulation of private sector in mental health provision, regulation of the qualification requirement for private providers, the quality of services etc.
		Integration with other policies/laws	Integration or links between mental health law and the mental health policy and other policies and laws
		Areas of action	Areas of action, suggestions, recommendations regarding the mental health law content
	Other laws/policies		Content of other laws and policies which have/should have mental health content e.g. disability policy, criminal justice. Include information on appropriateness, integration, areas of action.
MH Policy/law implementation			Objectives G and H
	Policy/law translation into plans		The process of translating mental health policy or law into plans, the effectiveness of translation, the content of plans and barriers in the process
	Funding for mental health		The amount and trends in funding for mental health. The sources of funding for mental health. The costs to users for mental health services.
	Mental health services and programmes		The mental health services and programmes in the country, including the organisation of services, the level of integration, the mental health infrastructure
		Organisation of mental health system	The way that the mental health system is organised, e.g. the structure and management, mental health system reforms, human resources, infrastructure
		Health sector mental health services	Description of implementation of mental health services, including promotion/prevention,

		treatment, support
	Other sector mental health services and programmes	Description of implementation of services and programmes mental health in other sectors, e.g. housing programmes, education programmes
	Integration with general health	The extent and ways in which mental health services are integrated or linked with other health services
	Integration with other sectors	The extent and ways in which mental health services are integrated or linked with other sectors
Mental health providers		(including mental health promotion, treatment, support etc.)
	Role of government health system	The role played by government health services in mental health promotion, treatment, support etc.
	Role of traditional healers	The role played by traditional healers in mental health promotion, treatment, support etc.
	Role of faith healers	The role played by faith healers in mental health promotion, treatment, support etc.
	Role of private for profit providers	The role played by the private for profit health providers in mental health promotion, treatment, support etc.
	Role of NGOs	The role played by NGOs in mental health promotion, treatment, support etc.
	Role of other sectors	The role played other sectors, e.g. education, social welfare, justice in mental health promotion, treatment, support etc.
	Users	Advocacy and self-help groups and projects
Policy		
	Effectiveness of implementation	The effectiveness of implementation of the mental health policy, e.g. regarding access, availability, quality of services provided, equipment etc.
	Stakeholders	The key stakeholders/actors

			involved in mental health policy implementation, their role and barriers to their involvement.
		Users	Barriers and opportunities for involvement with policy implementation specific to users
		Other stakeholders	Barriers and opportunities for involvement with policy implementation for other stakeholders
	Monitoring and evaluation		Monitoring and evaluation of implementation of the mental health policy.
	Resources		The use of and adequacy of resources in mental health policy implementation, e.g. human resources, funding.
	Challenges in implementation		Challenges in mental health policy implementation
	Areas of action		Areas of action, suggestions, recommendations or strategies to improve mental health law implementation
Law	Effectiveness of implementation		The effectiveness of implementation of the mental health law, e.g. regarding access, availability, quality of services provided, equipment etc.
	Stakeholders		The key stakeholders/actors involved in mental health law implementation, their role and barriers to their involvement.
		Users	Barriers and opportunities for involvement with law implementation specific to users
		Other stakeholders	Barriers and opportunities for involvement with law implementation for other stakeholders
	Monitoring and evaluation		Monitoring and evaluation of implementation of the mental health law.
	Resources		The use of and adequacy of resources in mental health policy implementation, e.g. human resources, funding.
	Challenges in		Challenges in mental health law

	implementatio n	implementation
	Areas of action	Areas of action, suggestions, recommendations or strategies to improve mental health law implementation
Research		
	Research agenda	The place of mental health on the health research agenda (the prioritisation of mental health research), funding for mental health research.
	Translation to policy	The extent to which research findings are used in policy, the ways research findings are translated for policy.
	Challenges	Challenges in mental health research
	Areas for action	Areas of action, suggestions, recommendations or strategies to improve mental health research.

7.4.2 Micro Level coding frame

Parent Node Child Node   Grand-Child Node

   1) Background

       a) Personal Background   Reasons Interest
                                        Perception MH
                                        Experiences MH
                                        Qualifications

       b) History Services
       c) Priority of MH
       d) Mental Health Plan
       e) Facility Type
       f) Role Played
       g) Resources & Services   Services Available
                                            Human Resources
                                        Other Resources

       h) Programmes Mental
       i) View Mental

   2) Management Frameworks & Intersectoral links
       a) District Management
          Committee
       b) Dedicated Person MH
       c) Multisectoral Forum
       d) Report Back MH

e) Training Needs Managers
f) Regional Support
g) Links Service Providers
h) Links Programme

3) Mental Health Problems
a) Cases Mental monthly
b) Training MH
c) Referral MH
d) Support MH
e) Hard times
f) Guidelines Mental

4) Serious Mental Health Problems

a) Staff   Additional Staff Needed
    Staff Full-time
    Staff Supervision
    Staff trained – Serious

b) Training Adult Serious
c) Support Adult Serious
d) Supervision

e) Role played MH
f) Services Provided
g) Admission & Assessment   Cases Serious monthly
    Average wait
    Distance Travelled
    Beds Available
    Other Bed Options
    Procedure for assessment
    Referral for Specialised Care

h) Involuntary Admission and Treatment
i) Seclusion & Restraint
j) Follow-up Care   Back Referral System Medication & Treatment
    Groups & Shelters Serious
k) Referral System   District Referral System
    Referral Forms
    Referral Sources
l) District System operation   District Needs & Problems
    System Operation

m) Disability Grant
n) Programmes Adult Serious
o) Facilities Adult Serious

5) Common Mental Health Problems
a) Cases Adult Common monthly
b) General Adult Common
c) Training Adult Common

        d) Support Adult Common
        e) Facilities Adult Common
        f) MH Issues Women
        g) Groups/Shelters Adult Common
        h) Programmes Adult Common

6) Children & Adolescents
        a) Cases Children monthly
        b) General Children
        c) Staff training Children
        d) Support Children
        e) Problems Children
        f) Treatment Children
        g) Facilities Children
        h) Referral Children
        i) Programmes Children
        j) Interventions Children

7) Traditional Healers Additional Items
        a) Become Healer
        b) Training Healer
        c) Diagnose Problem
        d) Diagnosis Mental
        e) Treatment Mental
    Facility type
    a) Organisation Member
    b) Interact Medical
    c) Interact Medicine
    d) Work together
    e) Other training
    f) Formal links
    g) Treatment charges
    h) Cases seen monthly
    i) Treatment children
    j) Integration of treated MH patients
    k) General comments
    l) Suggestions
    m) Challenges
    n) Future expectation
    q) Support MH
    r) Stigma
    s) Referral for further treatment
    t) Role played
    u) Awareness
    t) Referral Sources
    u) Poverty
    v) Gender
    w) View Mental
    Explanation

a) Participant
b) Users
c) Legislation knowledge
Human Rights
a) Respect, treatment & opportunities
b) User Particpation & Influence

8) Police Additional Items

    a) Educational Activities

    b) Contact with members of the public with MH problems

        Contact Public
        Identify and deal
        Training public
        Support Public
        Guidelines Public
        Procedure Escort
        Who Where
        Public Setting
        Procedure Request

    c) Contact with offenders with MH problems

        Contact Offenders
        Training Offenders
        Support Offenders
        Guidelines Offenders

    d) MH needs of victims & witnesses

        Guidelines Victim/Witness
        Training Victim/Witness
        Support Victim/Witness
        Procedure Victim/Witness
        Training Child offenders
        Training Child victim/witness

9) Social Work Additional Items

    a) Coping Workload
    b) Shortage SW Services
    c) Available help

9) Housing Additional Items

    a) Adults MH   Housing Needs
                     Governmental Housing
    b) Children MH   Housing Needs
                     Governmental Housing

    c) RDP Housing
    d) Guidelines Mental
    e) Problems Housing Provision

10) Education Additional Items

    g) MH Challenges Learners
    h) School MH Professional
    i) Identify MH problem

    j) Activities MH
    k) Teaching Experience

l) Learner MH experience
m) Learner MH Challenges
n) Learner MH Support

11) Magistrate Additional Items
        a) Contact MH
        b) Training Victim/Witness

12) User Additional Items

a) Help seeking and Symptom management/treatment	Age
	Approach First
	Complaints & Opinions
	Diagnosis
	Duration in hospital
	Gender
	Help-seeking & Medication
	Improvement in medication
	Knowledge Community
	Own Knowledge & Understanding
	People living with
	Policy – Service Accessibility
	Side-Effects & Availability of Medication
	Traditional and faith healers help
	Utilisation of services
	Wait period befor admission
b) Stigma and Discrimination	Attitude Gender
	Attitude Others
	Attitude Own
	Exclusion
	Help-Seeking Stigma & Discrimination
	Human Rights
	Police or Legal contact
	Protection from Discrimination
	Respect & Dignity
	Stigma
c) Advocacy and Policy level Participation	Awareness
	Exposure
	Participation
d) Basic Needs of people with mental health problems	Housing Where
	Employment
	Education & Skills
	Food
	Benefits & Grants
	Money
	Transport
	Self-care & Household Chores
	Social contact & activities

		Intimate Partner
		Childcare
		Impact MH problem
		Gender relationships
		Harm & Suspicion
		Water & Electricity
		Feeling sad & depressed
	e) General	Comments
		Future Expectation & Suggestion
		Government Help
		Information results
		Readings

13) Socio-economic & Cultural

- e) Budget Mental
- f) Department Needs
- g) Vacant Posts
- h) Medication & Tests
- i) Poverty
- j) Gender
- k) Explanations — Explanation – Participant / Explanation - Users
- l) Traditional Medicine
- m) Language Issues
- n) Stigma
- o) Health Seeking Behaviour
- p) Social Factors

14) Legislation, Policy & User Rights

a) Legislation/Policy	Legislation/Policy Knowledge
	Legislation/Policy Input
	Legislation/Policy Training
	Legislation/Policy Impact
	Legislation/Policy Need for change
	Legislation/Policy Implementation
	Other Legislation
	Norms and Standards
b) User Rights	Respect, treatment & opportunities
	User participation
	User influence
	Human Rights

15) General Comments

- a) General Comments
- b) Burden of MH
- c) Integration of MH
- d) Challenges
- e) Suggestions

f) Future Expectations

Attributes

Attribute	Values
Respondent type	Policy maker at national level
	Policy maker at regional level
	Programme manager at national level
	Programme manager at regional level
	Politician at national/regional level
	Other government sectors
	External development partner
	Media representative
	Academic/ researcher
	Mental health user key informant
	Private sector or NGO (service providers and/or advocacy)
	Religious or community leader
	Traditional healer key informant
	Union or professional association
Medical professional	Medical professional (doctor, nurse, psychiatrist, PCO etc)
	Not medical professional
Gender	Male
	Female
Country	Ghana
	South Africa
	Uganda
	Zambia

7.5 Appendix 5: Ethical Clearance

7.5.1 Sample of informed consent form for FGD

Good morning/afternoon. My name is _____ from _____. We are conducting focus group discussions with people, like yourself about how mental health policies are developed and implemented in (*country*). The purpose of this study is to gather information that will help us to **understand the factors necessary for the development and effective implementation of appropriate mental health policy in (name of the country).** I would like your permission to talk with you today about your ideas and experiences related to mental health in this country.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential. Your name will not be used in any reports of our research findings.

It is up to you if you wish to answer any or all of my questions. The discussion should take no longer than ___ minutes but can be stopped by you at any point.

Do you have any questions about the purpose of the discussion or how the discussion will be conducted?

If you agree to participate in this discussion, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

I agree to take part in this discussion

I   agree / do not agree   to be tape recorded
(cross out as appropriate)

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during your discussion, please contact Dr_____ (country coordinator) at _____ (telephone number).

7.5.2 KHRC Institutional Ethical Committee Approval

Ethics Approval No:

The Chairman
Institutional Ethics Committee
KHRC
Box 200.
05/12/06.
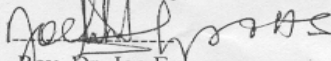
Mr. Bright Akpalu
MHAPP
KHRC.

Dear Research Officer,

Full Ethical Approval 'Mental Health and Poverty Project'

Following your successful amendments to the above named protocol, I am glad to inform you that your protocol has been granted full ethical approval for the commencement of this part of your study. As you rightly stated in your amendments letter, you would be required to submit a separate protocol for ethical clearance should your outcomes change.

You are however being reminded that as per the requirements of the ethical review board, you would be required to submit progress reports and a final report of the study to the board. The forms to aid you satisfy these requirements can be made available to you at the IEC secretariat.

Please accept our congratulations and best wishes in this very important study!

Yours Faithfully,

Rev. Dr. Joe Eylson
(Chairman)

7.5.3 KHRC Scientific Review Committee Approval

In case of reply the
number and date of this

letter should be quoted.

My Ref.
Your Ref. No.

Kintampo Health Research Centre
Ghana Health Service
P. O. Box 200
Kintampo.
Brong Ahafo Region

Tel: +233-61-27304
    Mobile +233-24-3323 967
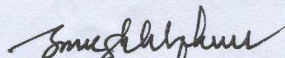Fax + 233-61-24145

August 22, 2006

The Principal Investigator
Mental Health and Poverty Project
Kintampo Health Research Centre
Box 200
Kintampo.

Dear Sir or Madam,
Approval of protocol by the Scientific Review Committee

Your protocol entitled **"Mental health policy development and implementation in four African countries: breaking the cycle of mental ill-heath and poverty"** has been approved by the Scientific Review Committee.

Accept my congratulations on behalf of the SRC, and I wish you well in this important research.

Bright Akpalu
(Secretary)

7.5.4 Ghana Health Service Ethical Review Committee Approval

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

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

Health Research Unit
Ghana Health Service
P. O. Box GP-184
Accra

28th September 2006
Tel: +233-21-681109
Fax + 233-21-226739
Email: Hannah.Frimpong@hru-ghs.org

*My Ref. :GHS-ERC: 3
Your Ref. No.*

ETHICAL CLEARANCE
ID NO: GHS-ERC – 01/9/06

The Ethical Review Committee of the Ghana Health Services at its sitting on 27th September 2006, gave approval for the implementation of your Protocol title:

"Mental Health Policy Development and Implementation in four African Countries: breaking the cycle of mental ill-health and poverty".

PRINCIPAL INVESTIGATOR: Dr. Victor Doku

This approval requires that you submit periodic review of the protocol to the Committee and a final full review to the Ethical Review Committee (ERC) at the completion of the study. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

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

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

You are requested to inform the ERC and your mother organization before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this protocol.

SIGNED...
PROF. ALBERT GEORGE BAIDOE AMOAH
(GHS-ERC CHAIRMAN)

Cc: The Director
     Health Research Unit
     Ghana Health Service
     Accra