

The Status of Mental Health Care in Ghana, West Africa and Signs of Progress in the Greater Accra Region

Olivia Fournier
Department of Integrative Biology '12

Abstract

Mental health care is becoming a critical international concern, but developing countries are still straining to attend to the mental health needs of their suffering and stigmatized citizens. This study assessed the situation of mental health care in Ghana, an Anglophone democratic republic in West Africa. For four months, interviews and secondary data were conducted and collected in the Greater Accra Region to gain information on the available mental health services, the condition of psychiatric hospitals, the most common diagnoses, the challenges the mental health system faces, the changes that need to occur, and the progress made thus far. Currently, the few psychiatric hospitals they have are severely congested, the number of mental health professionals is staggeringly low, community and rehabilitative care is non-existent, and the law on mental health has not changed in over thirty years. This is all due to inadequate funding, a longstanding stigma, the low fatality of mental illness, and the government's ambivalence towards mental health. Mental health personnel and NGOs have been involved in increasing the awareness of mental illness and improving the delivery of mental health care, but there are still many changes that need to take place in order to secure the rights of the vulnerable, and provide equal access to mental health treatment for all Ghanaians.

Introduction

Recently, neuropsychiatric disorders have been conservatively estimated to be 14% of the global burden of disease, more than the burden of cardiovascular disease or cancer, and their conditions account for a quarter of disability adjusted life-years (the sum of years lived with disability and years of life lost) [14]. The World Health Organization (WHO) also estimates that 25% of the world's population will suffer from mental, behavioural, and neurological disorders such as schizophrenia, mental retardation, alcohol and drug abuse, dementias, stress-related disorders, and epilepsy during their lifetime [15, 1, 14, 16]. Mostly affecting the poor and people from developing countries, depression impinges on more than 450 million people and might become the second most important cause of disability by 2020 [11]. Despite these new insights, as the 20th century revealed Herculean advancements in somatic healthcare worldwide, the mental aspect of healthcare has remained stagnant and in some cases, gravely depreciated.

Mentally ill people are some of the most vulnerable people in society. They are often subject to discrimination, social isolation and exclusion, human rights violations, and an ancient, demeaning stigma which leads to bereavement of social support, self-reproach, or the decaying or straining of important relationships [4, 5, 14]. Consequences of poor mental health also include being predisposed to a variety of physical illnesses, having quality of life be reduced, having fewer opportunities for income, and having lower individual productivity, which affects total national output. Poor mental health can also account for violence, drug trafficking, child abuse, paedophilia, suicide, crime, and other social vices [12].

Even though mental health is becoming a serious international health concern, many countries, specifically the more impoverished countries, struggle to address the inadequate amount of resources being funnelled into the non-physical sector of health. Low-income countries often have insufficient implementations of policies and limited mental health services confined to short-staffed institutions. Furthermore, in both developed and undeveloped countries, the poor are more vulnerable to common mental disorders due to experiences of rapid social change, risks of violence, poor physical health, insecurity, and hopelessness [13, 4]. Women, slum dwellers, and people living in conflict, war prone, and disaster areas of civil unrest constitute a large portion of the population in developing countries, and are specifically susceptible to the burden of mental illness. For instance, 90% of the 12 million worldwide schizophrenia sufferers who do not receive adequate psychiatric services are located in developing countries [11].

Only 50% of countries in Africa have a mental health policy, and if they do have a law, it is usually archaic and obsolete. Ninety percent of African countries have less than one psychiatrist per 100,000 people, and 70% of the countries allocate the mental health sector with less than 1% of the total health budget [8]. Less than 60% of African countries have community mental health care while the rest are focused on psychiatric hospitals [2]. The World Psychiatric Association suggested that the development of mental health programmes are impeded in Africa because of the scarcity of economic and staff resources, lack of awareness on the global burden of mental illness, and the stigma associated with seeking

psychiatric care. Mental health has been shunned in Africa, and several reports disclose a higher prevalence of stigma in developing countries than in first world countries [3].

Similar to many other developing countries, treatment of mental health in Ghana, West Africa is low and continues to rely on institutional care, a vestige from colonialism [16]. In Ghana, it is roughly estimated that at least 2,816,000 people are suffering from moderate to severe mental disorders, and only 1.17% of these people receive treatment from public hospitals because only 3.4% of the total health budget is dedicated to psychiatric hospitals [16]. Because there is one psychiatrist per 1.5 million people in the whole country, and the three major psychiatric hospitals (which are ironically located only in Southern Ghana) are under-financed, congested, and under-staffed, many resort to more ever-present and more affordable, traditional or faith healing [9]. Ghana has a deep-seated tradition of religious (Animist, Christian, and Muslim) observance. Thus, 70–80% of Ghanaians utilize unorthodox medicine from the 45,000 traditional healers, located in both urban and rural areas, for their vanguard healthcare despite recent advances in orthodox psychiatric services [3, 16, 9]. Although research shows that mental-health patients who used spiritual healing usually reported an improvement in their condition, the quality of treatment is not easy to ensure [4, 5, 16]. Sometimes in order to exorcise supposed demons, individuals are chained, flogged, or incarcerated into spiritual, prayer camps [12].

In spite of these atrocious facts, policy-makers seem to have little concern for mental health, and focus more on physical health and population mortality. The Lunatic Asylum Ordinance of 1888, enacted by the Governor of the Gold Coast, Sir Griffith Edwards, marked the first official patronage to Ghana's mental health services. This ordinance encouraged officials to arrest vagrant "insane people and place them in a special prison in the capital city of Accra. After the prison quickly filled, a Lunatic Asylum was built in 1906. In accordance with international trends, the asylum was later transformed into the Accra Psychiatric Hospital in 1951 with help from the first sub-Saharan psychiatrist, Dr. E. F. B. Foster. With high walls and barbed wire, to this day the hospital still resembles a prison, which harks back to how the mentally ill were dealt with during colonial times. Luckily, innovations such as the removal of chains from patients, abstaining from patient punishment, and use of chlorpromazine and electroconvulsive therapy arose in the fifties. During that time, the Accra Psychiatric Hospital was the only psychiatric facility in West Africa [9]. In 1962, the Ghana Medical School started training undergraduates in psychiatry and a Mental Health Unit was formed within the Ministry of Health in the 1980s [1]. Though Ghana's psychiatric care has come a long way since the 1800s, there are still a lot of changes that need to occur in order to attain a standard of quality that is appropriate to recent advances. Ghana's Mental Health Decree, which emphasizes institutional care and involuntary admission, has not changed since 1972, and treats the mentally ill as if they have no rights [16]. Fortunately, a new Mental Health Bill, which was drafted in 2006, finally made it into the lap of Parliament in October of 2010. This legislation will promote practice of mental health care at the community level and protect the rights of people with mental illnesses. It has gained the support of traditional healers, nurses, and doctors, and will serve as a model for developing progressive mental health legislation in line with international human rights standards.

Several researchers have noted a need to increase accurate and comprehensive

data collection on mental health impact and prevalence in order to help improve perceptions on the legitimacy of psychiatric services, and ultimately influence policy [2, 8]. Due to a shortage in personnel, there is a deficit of mental health information, hard community based data, and scientific estimates for neuropsychiatry disorders in Ghana [5, 1]. Because the World Health Organization's agenda for mental health research in the developing world suggested to evaluate mental health services, this paper focuses on two of the three psychiatric hospitals, and analyzes the hospitals' available services, resources, recent annual number of out-patients and in-patients, and most common diagnoses which have not been published since 2003 [10]. In an attempt to provide an argument for improving the resources and commitment to mental health, this paper also reports on the status of mental health care via information from interviews with key people in the mental health delivery system and non-governmental agencies involved in mental health.

Research Questions

1. What type of care and services are available to mentally ill Ghanaians?
2. How many inpatients and outpatients attend the psychiatric hospitals and what are the most common diagnoses?
3. What condition are the psychiatric facilities in?
4. What are the main challenges and problems facing mental health care in Ghana?
5. What changes need to occur in the mental health system?
6. Are there any recent signs of progress?

Methods

Study Site

Ghana is a middle-income, developing, constitutionally democratic republic located in sub-Saharan West Africa along the Gulf of Guinea in between Côte d'Ivoire and Togo. Once a British colony of the Gold Coast, in 1957, Ghana was the first sub-Saharan country to gain its independence and is relatively politically stable. The population estimate for July 2011 is 24,791,073. The life expectancy is 61 years and high risk infectious diseases present include malaria, typhoid fever, meningococcal meningitis, hepatitis A, and diarrhoea. Malnutrition and poor reproductive health are also familiar problems to sub-Saharan countries. There are three prominent religions; 68.8% of Ghanaians are Christian, 15.9% are Muslim, and 8.5 percent follow a traditional religion. The official language is English but there are about 100 linguistic and cultural groups in Ghana, and English only accounts for 36.1% of the population's primary language. The 2010 GDP, purchasing power parity, was \$38.24 billion dollars, with one-third produced agriculturally. Gold, cocoa, and timber are the country's main exports and recent oil production is expected to heighten economic growth. Twenty-eight and one half percent of Ghanaians live below the poverty line and 11% are unemployed (Central Intelligence Agency 2011). Ghana's health expenditure is roughly 4.5% of the Gross National Product, compared to 15.2% in the US (Barke et al. 2010). Ghana is divided 10 regions and 170

districts. Due to the proximity to the University of Ghana, Legon Campus, interviews were conducted in the metropolitan capital city, Accra (5° 33' 0" N, 0° 15' 0" W), and in the surrounding Greater Accra Region, which lies on the south-east coast.

Design of Work

Mixed methods were used to obtain data. In-depth interviews gained qualitative information while logistical, secondary data was acquired through visits to the records departments of psychiatric hospitals. Other research included touring the Accra Psychiatric Hospital and volunteering at the Accra Psychiatric Hospital's Children's Ward, Castle Road Special Needs School (CAROSS), and Special Education Needs, Counselling and Drama-therapy Centre (SENC-DRAC).

Data Collection

In order to gain first-hand information and opinions on the current mental health situation in Ghana, 1.5-3 hour interviews were conducted with prodigious psychiatrists and a mental health NGO during spring of 2011. The first two interviews were with Dr. Akwasi Osei, the acting Chief Psychiatrist of the Ghana Health Service and Administrative Head of the Accra Psychiatric Hospital, the oldest and main psychiatric hospital in Ghana. In addition to holding these positions for the past six years, Dr. Osei is also a senior lecturer, researcher, and spokesperson for Ghana's mental health care. The first interview dealt with matters based on Ghana's mental health system and the stigma of mental illness, while the second interview addressed the logistics and condition of the Accra Psychiatric Hospital. Dr. Anna Dzadey, a psychiatrist from Poland, was the second interviewee. She has been the Medical Director and Psychiatric Specialist in charge of the Pantang Mental Hospital since 2005. Dr. Dzadey provided ample amounts of information on the Pantang Hospital, one of the three psychiatric hospitals in Ghana. One of the most prominent mental health NGOs in Ghana, MindFreedom, was also interviewed to learn how they are helping to improve the care available to the mentally ill, and to see if they are noticing signs of advancement. The interview with MindFreedom involved Janet Amegatcher, Nii Lartey Adico, and Dan Taylor, the executives and founders of the NGO.

Results

Services Available

In all of Ghana, there are only three public psychiatric hospitals and four private psychiatric hospitals. The three public hospitals, Accra Psychiatric Hospital, Pantang Hospital, and Ankaful Psychiatric Hospital, are all located in the South, with two in the Greater Accra Region and one about three hours away (by car) in Cape Coast in Ghana's central region. Treatment for mental health care in government hospitals is free and is funded by the Ghana Health Service, which allocates a mere, debatable 0.5–3.4% of the health budget to the mental health

sector [16, 3]. There are also four private psychiatric hospitals, two in Kumasi, one in Accra, and one in Tema (18 km from Accra). Although Kumasi is not along the coast, it is still in the southern half of Ghana. The private hospitals are criticized for being too expensive, and it is said that their patients usually end up at a public hospital once their resources are drained. It is uncertain whether the quality of care at a private psychiatric hospital is superior to that of a public hospital, but there are most likely better accommodation, less congestion, and more doctor-patient contact time.

The Accra Psychiatric Hospital offers in-patient and outpatient services, limited counselling and therapy, and clinical training for doctors, psychologists, and psychiatric nurses. Technically, all services are free to the Ghanaian public, but some small fees are charged in order to help keep the hospital running. New patients are obliged to pay four Ghana cedis ($\approx$ \$2.70) for a hospital records folder, ID card, and some forms. Patients are also asked to pay about 80 pesewas (54 cents) for their medication, which can cost up to 400 Ghana cedis. In turn, this helps the patient to value the medicine on top of providing money for the hospital. Typically two psychiatric nurses and two aids (orderlies or assistants) work in each ward on a daily basis, taking care of an unbelievable amount of patients by dispensing medication, noting observations, feeding, washing, and offering group therapy if there is any time or motivation left. The nurses write down the progress of each patient almost every day, but when asked how often the doctors review these notes, the nurses laughed and encouraged me to ask the medical director of the Accra Psychiatric Hospital. Although doctors should be checking in on their inpatients every day, in actuality, it happens about every two weeks due to the overload of outpatients and inpatients. A nurse will usually only report to a doctor if the condition of the patient has become very poor or if they believe the patient is well enough to be discharged.

The Pantang Hospital, the largest (acreage wise) of the three psychiatric hospitals, was commissioned in the rural Pantang Village in the Greater Accra Region in 1975 in order to reduce the congestion at the Accra Psychiatric Hospital. It was planned to be a regional psychiatric hospital with a 500 bed capacity, but in addition to the original psychiatric services, the hospital now offers primary health care, reproductive and child health services, and, under the National Health Insurance Scheme, HIV counselling, screening, and ART (anti-retroviral treatment) service. The psychiatric services are free by description, but similar to the Accra Psychiatric Hospital, Pantang asks patients to pay a small fee for their folders and medication if they can afford it. Nurses, nursing students, Health Assistant Training School students, and Community Health Mental Officers also gain clinical psychiatric experience at the Pantang Hospital.

Community mental health care exists in Ghana, however, it is not well developed. A Community Psychiatry Nursing Programme began in 1975, and there are currently 120 Community Psychiatric Nurses (CPNs) working in all ten regions, but some regions may have just one or two CPNs. The nurses are not distributed evenly throughout the country, and only 70 districts out of 170 are covered by at least one CPN. To become a CPN, a psychiatric nurse only has to train for three to six weeks after their completion of the mental nursing program but soon there will be an official degree program that spans over one or two years. Dr. Osei believes that there should be at least 2,000 CPNs working in the country in order to provide adequate community based psychiatric care.

CPNs are responsible for identifying and managing cases, referring cases to the next level of care, counselling, providing after-care services (including outpatient care in the districts and regions), and creating awareness and promoting mental health in the community [1].

In addition to institutional care and community mental health, another key component of treatment is traditional healing. Due to the nation-wide presence of unorthodox healthcare and the Ghanaian belief that mental illness is caused by spiritual forces, traditional and spiritual healers tend to be the largest sum of mentally ill sufferers in the country. Even urban people who live near the three psychiatric hospitals frequently visit spiritualists [5]. Dr. Osei believes that traditional or faith healing, which uses herbal preparations and/or spiritual incantations/invocations, could be valuable if the administrators recognized their limits. Minor disorders like anxiety, minor depression, neurosis, phobias, or OCD, which might not require medication for treatment, can sometimes benefit from the therapy provided by healers. A healer is typically well trusted and has considerable influence over one's emotions, so a patient might subsequently change their way of thinking after treatment, or receive reassurance that whatever provoked the problem has been removed (or exorcised) in a spiritual manner. However, except for the occasional use of antipsychotic herbs prescribed by herbalists, traditional healers generally cannot help a person suffering from a severe mental disorder.

It is well reported that abuse of the mentally ill occurs at prayer camps. In a documentary released by MindFreedom Ghana, the mentally ill are chained to trees, exposed to the sun and rain, deprived of food and/or water, and even chained or flogged in an attempt to exorcise the supposed demons. The violations of a mentally ill person's human rights have yet to be curbed because there are no laws governing mental health care outside of the psychiatric hospitals [1]. Nonetheless, seeing a faith healer is seemingly less stigmatizing than visiting a psychiatric hospital. A mentally ill person is usually shown some sympathy from the community if they attend therapy from a traditional healer while no empathy is given to one who visits a mental hospital. The executives of MindFreedom encourage a balance between faith healing and physical treatment when necessary, agreeing that seeing a traditional or faith healer brings fewer stigmas and is more convenient transport wise. Because of this, the normal pattern for Ghanaians involves utilizing traditional care first and then going to a psychiatric hospital if the problem was not cured. Twenty to thirty percent of the Accra Psychiatric Hospital's patients try spiritual or traditional healing before a family member or the court brings them to the psychiatric hospital. About 20% of patients use faith healing after leaving the hospital for spiritual reinforcement.

Attendance

Patients at the Accra Psychiatric Hospital and Pantang Hospital travel from all over the country and surrounding countries such as Togo, Côte d'Ivoire, Benin, Burkina Faso, and Nigeria. On an ordinary day at the Accra Psychiatric Hospital, around 100 to 400 outpatients are seen, ten patients are admitted, and nine patients are discharged from the hospital wards. Dr. Osei extrapolates that about 40,000 outpatients were seen in 2010, but this number might not be very accurate due to faulty forms. Outpatient attendance has reportedly shown an

Table 1: Number of admissions from January–December 2010 at the Accra Psychiatric Hospital.

Age Group	Male	Female	Total
10–14	17	167	184
15–17	234	186	420
18–19	343	210	550
20–34	176	142	318
35–49	685	626	1,311
50–59	381	345	726
60–69	38	62	100
70+	20	19	39
Total	1,894	1,757	3,651

Table 2: Number of discharges from January–December 2010 at the Accra Psychiatric Hospital.

Age Group	Male	Female	Total
5–14	2	1	3
15–44	882	748	1,630
45–59	313	271	584
60+	43	58	101
Total	1,240	1,078	2,318

increasing trend since 1995 [4]. The number of inpatient admissions is no longer increasing because the hospital's psychiatrists are now more stringent on their criteria for admittance. Patients are admitted into a ward if they are a danger to themselves or others, if they require medication that cannot be administered on an outpatient basis (injections or electro-shock), or if they are ordered into a psychiatric hospital by the court. The maximum occupancy of the hospital is 600 but there are currently 1,000 inpatients living in the wards, and there were 1,200 inpatients in January 2011. Table 1 and Table 2 reveal the numbers and ages of patients admitted and discharged in the year 2010.

In 2010, Pantang Hospital assessed 18,503 psychological outpatients; 9,143 were male and 9,360 were female. There was a 4.9% increase in outpatients from 2009, when only 17,636 patients were seen. The number of psychological outpatient cases has been gradually increasing since 2005. According to data collected from 2004 to 2010, the hospital sees on average a total of 33,410 outpatients per year for both general and psychological causes, with just 15,894 of that number owing to psychological purposes. A range of 20 to 100 psychological outpatients can be seen a day.

One thousand five hundred and thirty-nine patients were admitted into the Pantang Hospital in 2010, which reveals a 5.9% decrease in the number of inpatients from 2009. Usually, the number of patients admitted increases between 2.2% to 33% from year to year, though a decrease in attendance (11%) was also observed between 2006 and 2007. Over the past seven years, the hospital on average admits 1,371 patients per year, and about ten to twelve patients a day. Table 3 shows the number of patients who were admitted, discharged, and died according to each year. The dashes symbolize a lack of information.

Table 3: The annual cycle of patient turnover at the Pantang Hospital from 2004–2010.

	2004	2005	2006	2007	2008	2009	2010
Admissions	1,090	1,114	1,482	1,318	1,415	1,636	1,539
Discharges	–	–	–	1,282	1,407	1,735	1,105
Deaths	–	–	–	–	6	8	9

Diagnoses

It is hard to tell whether there has been an increase in the number of diagnoses of a certain mental disorder within the past decade. The rise in numbers could be a result of increased awareness or a larger population. In addition, it is difficult for Ghanaian psychiatrists to ensure uniformity in diagnosis because of different backgrounds in training and cultural perspectives. Several years ago, the Pantang Hospital, along with the other two psychiatric hospitals, began using the International Classification of Mental and Behavioural Disorders—Tenth Revision (ICD-10), which groups mental disorders into categories and subcategories and assigns each disorder a code number. Even though the ICD-10 helps systemize and standardize diagnosis, speeds up the digitalization of record, and simplifies comparisons between years, hospitals, and countries, many Ghanaian medical professionals have not been consistent in their usage of the classification system. Old patients should also be re-diagnosed using ICD-10 but because of the additional time this takes, it rarely happens.

Possibly due to the non-uniformity in diagnosis, there also have been few consistent patterns of having a higher number of males or females being diagnosed with a specific mental illness. However, Dr. Osei reported that women in Ghana are most commonly diagnosed with depression and bipolar disorder while the majority of mentally ill men are diagnosed with bipolar disorder or substance abuse, specifically cannabis. Many Ghanaian women also suffer from anxiety while men suffer from alcohol abuse, but both sexes are unlikely to visit a psychiatric hospital for these problems. The most common reason for admission into a psychiatric hospital in Ghana is schizophrenia. There has been no attempt to get an accurate number of the amount of Ghanaians currently suffering from a mental illness thus far but the next census is supposed to include questions addressing the amount of mentally ill inhabitants in a household. Because medical professionals are preoccupied with long hours of clinical work, there is a severe lack of information and hard data focused on mental health and neuroscience in Ghana. There has been no attempt to obtain an accurate number of the amount of Ghanaians currently suffering from a mental illness thus far, but the next census is supposed to include questions addressing the amount of mentally ill inhabitants in a household.

Schizophrenia, depression, epilepsy, and substance abuse of alcohol and cannabis are the most common diagnoses at the Accra Psychiatric Hospital and the Pantang Hospital. The records department at the Accra Psychiatric Hospital imparted the most common diagnoses for new cases in 2010, seen in Table 4, while Table 5 shows the most common psychiatric diagnoses amongst outpatients at the Pantang Hospital.

Between 2009 and 2010, the Pantang Hospital saw a drastic increase in the number of outpatients diagnosed with mental disorders due to alcohol abuse

Table 4: The top ten diagnoses at the Accra Psychiatric Hospital of new patients from January–December 2010.

Condition	Male	Female	Total
1. Depression	1,329	2,133	3,462
2. Schizophrenia	1,450	1,678	3,128
3. Epilepsy	688	517	1,205
4. Substance Abuse	571	454	1,025
5. Hypomania	345	177	522
6. Neurosis	292	126	418
7. Dementia	79	179	258
8. Acute Psychosis	72	181	253
9. Schizo-Affective Psychosis	89	45	134
10. Others	28	33	61
Total	4,943	5,523	10,466

Table 5: Top six psychological out-patient diagnoses at the Pantang Hospital in 2010.

Condition	Male	Female	Total
1. Schizophrenia, schizotypal and delusional disorders	4,350	4,855	9,205
2. Depression and mood (affective) disorders	928	1,592	2,520
3. Epilepsy	1,175	1,146	2,321
4. Unspecified mental disorders	–	–	2,132
5. Mental disorders due to alcohol use	1,777	49	1,983
6. Mental disorders due to cannabis use	1,569	72	1,641

Table 6: Top six causes for admission to the Pantang Hospital in 2010.

Condition	Male	Female	Total
1. Schizophrenia, schizotypal and delusional disorders	612	703	1,438
2. Mental disorders due to cannabis use	587	36	623
3. Depression and mood (affective) disorders	182	191	373
4. Mental disorders due to alcohol use	249	36	285
5. Unspecified mental disorders	—	—	278
6. Mental disorders due to other psychoactive substance use	188	10	198

(211.7% increase), cocaine use (118.8%), and other psychoactive substance use (205.9%). Outpatient diagnoses of behavioral syndromes (physiological and physical factors), adult personality and behavioral disorders, and epilepsy also displayed a significant increase in 2010. Schizophrenia and depression remained the leading diagnoses in 2009 and 2010. The most common cases for admission at the Pantang Hospital can be seen in Table 6.

Conditions of Psychiatric Hospitals

The Pantang hospital receives its funding from the government, internally generated funds, and donations. In 2010, their aid totalled to 1,742,185.25 GH cedis, 1,245,730.85 (71.5%) of which was given by the government. Donations amount to .88% of funding and internally generated funds from drugs and services represent 27.6% of annual income. Unfortunately, the hospital has been increasingly in debt over the past six years, and in 2010, the indebtedness totalled to 766,994.09 GH cedis. The government spends about four million Ghana cedis a year on the Accra Psychiatric Hospital, as the hospital is in debt and usually expends seven million a year, but receiving ten million would help things run more smoothly. Overshadowed by stigma, the psychiatric hospital receives little in donations, which amounts to about one percent of the total funding. Because of funding, the Accra Psychiatric hospital has 60–80% of the medicine they need, and most of the medicine they are given is older generation which cause negative side effects such as twisting of the neck, numb tongues, and metabolic problems.

At Pantang Hospital, the in-patient sector of the hospital consists of nine wards (two of which are VIP wards) with 50 beds, and any extra patients sleeping on thin mattresses. The VIP wards, which cost money to stay in, do not necessarily receive better treatment, but the rooms are less crowded (possibly a single), the food is better quality, and there is air conditioning. At the Accra Psychiatric Hospital there are 3 infirmaries and 23 wards total; 16 are male, six are female, and there is one children's ward. One of the female and one of the male wards are reserved for geriatric cases. The largest special ward is reserved for forensic court cases and more aggressive males, 234 of them in total, though the official occupancy is only 60 for that particular ward. The largest female equivalent ward has 110 patients but the average number of patients in a ward is close to 50.

Because there are only 500 beds (3-inch thick foam mattresses) and currently

1,000 inpatients at the Accra Psychiatric Hospital, the congestion leaves 500 patients to sleep on the concrete or on thin mats either inside or outside. There are no fans or air conditioning either. The ones forced outside without insecticides or mosquito nets are subject to the rigors of the weather during the day and the disease carrying mosquitoes at night. These unlucky ones also share their space with ants, cockroaches, and rats. Though there is tap water available, drinking it is not encouraged, so patients have to pay a small fee for filtered drinking water. Patients eat three low quality meals a day that usually consist of rice, adding up to 3.60 cedis a day (\$2.40), a recent increase from the 1.20 cedis spent before 2011. Uniforms are not provided so the patients are free to wear their own or donated clothes, however it is a common and disturbing sight to see people running around stark naked or half naked with tattered clothes hanging loosely off their body. The congestion of patients and the conditions of their living situation are human rights violations in and of themselves. To add to the situation, Dr. Osei admitted that behind the scenes, patients are sometimes physically or medically punished by nurses who are trying to control more patients than is feasibly possible. An undercover journalist also witnessed this injustice as well as pervasive drug trafficking between patients and employees. Although these acts are strictly discouraged, it is hard to prevent these human violations from occurring due to a lack of staff and security.

Records are kept analog, in a room full of bulging, tattered folders; though they are trying to digitalize the system, it is difficult with only 15 of the necessary 100 computers. There is also an intercom that works 80% of the time. The building, initially built as a prison and not as a hospital, is 100 years old, which makes it gruelling to clean and maintain. There is asbestos in the roofing, sewage system pipes have broken, and the buildings look like a rundown dog pound instead of a pristine, sanitary hospital. In fact, people in the West would be appalled by the conditions even if it actually were a place reserved for rogue dogs. If the Mental Health Bill passes, then remodelling of the building might start in seven years' time. Dr. Osei proposes that if the buildings and wards ameliorate into sane conditions, then the morale of both the workers and patients will improve, and people will not want to leave the second they arrived.

Pantang Hospital's accretion of debt from insufficient funding over the past six years has led to unfinished structures, outdated equipment, shortage of prescribers, inadequate treatment programs (i.e. rehabilitation), poor food quality, deficient road networks, old vehicles, under-supplied water and electricity, and encroachment of land and security. During my interview with Dr. Dzadey, the electricity went out in true Ghanaian fashion, and was followed by many scolding and worried phone calls about the number of the samples the laboratory was losing every minute the generator refused to work. Water enters the pipes only twice a month so there is not enough water or disinfectants to properly clean the estate. In addition to that, the hospital is constantly buying water to fill tanks and filtered water to give to patients. The regular wards feed each patient on a mere 60 pesewas (40 cents) a day, but in 2008 it was rightfully increased to 2.5 cedis. Though the walls are covered in perma-dirt, and dust and a smell of sanitation chemicals lingers in the air, the facilities are much nicer and newer than at the Accra Psychiatric Hospital. The outpatient psych department is located in a three-story building, with a television in the lobby, and there is air conditioning in the consultant rooms. Possibly due to the workload and training, Dr. Dzadey also commented on how the nurses do not have the proper

Table 7: Human resources in Ghana's mental health care system in 2011.

Occupation	Current Number	Number Needed	Gap
Psychiatrists	11	80	69
Clinical Psychologists	3	80	77
Occupational Therapists	1	110	109
Psychiatric Nurses	600	3,000	2,400
CPNs	120	2,000	1,880

understanding on how to take care of patients. They complete their tasks, such as administering medicine, but there seems to be a lack of compassion in regards to keeping the patients' best interests at heart.

Challenges and Problems

Ghana has only 11 psychiatrists, four of them at the higher, board certified consultant level, and 6 retired psychiatrists, four of whom continue to work at private psychiatric hospitals. In order to have an effective mental health care system in Ghana, Dr. Osei believes that there should be at least 80 working psychiatrists with half of them at the consultant level. To become a consultant psychiatrist in Ghana, one will have to complete six or seven of medical school, then five years (three years for a general psychiatrist) of post-doctoral work in psychiatry. "Brain drain is a phrase all too common to the mental health care system in Ghana. Many Ghanaian mental health professionals go overseas seeking better pay and better conditions. Shockingly, there are currently twenty Ghanaian psychiatrists practicing in the U.K. when there are only seventeen psychiatrists in all of Ghana. While here is one retired occupational therapist in Ghana, Dr. Osei conservatively requests for twenty. In actuality, every mental health unit should have an occupational therapist, so the ideal number would be around 200. Hence, in Table 7 I averaged 20 and 200 to get a more accurate estimate of the amount needed. Furthermore, there are only 600 Psychiatric Nurses presently working when there should be at least 3,000 in order to care for most of Ghana's mentally ill. Psychiatric Nurses train at either Pantang or Ankaful, and complete one year of general nursing and two years of specialized psychiatric nursing. Clinical psychologists are regrettably not even recognized by Ghana's Ministry of Health, and any clinical psychologists working at a Psychiatric Hospital have to be listed under another title on the payroll. A concise summary of the lack of mental health personnel is presented in Table 7.

There is a severe lack of human resources at the Psychiatric Hospitals. Seven psychiatrists (three are consultant psychiatrists) are working at the Accra Psychiatric Hospital when there should not be less than 30 psychiatrists. Dr. Osei referred to this number as his "dream figure. Table 8 presents other current and proposed numbers of staff. Although there are no trained psychiatric social workers, there are two generic social workers employed by the hospital. The hospital also has two volunteers who help feed and bathe the children in the children's ward. There should be two security workers in every ward and some more patrolling the hospital, which led to the suggested fifty. Because of the lack of security, many patients escape by jumping over a wall, exiting through a ceiling, or simply walking out of the front entrance. Also, there is typically one

Table 8: Human resources at the Accra Psychiatric Hospital in 2011.

Occupation	Current Number	Number Needed	Gap
Psychiatrists	7	30	23
Consultant Psychiatrists	3	15	12
Clinical Psychologists	1	10	9
Occupational Therapists	0	4	4
Psychiatric Nurses	200	600	400
Pharmacists	3	6	3
Psychiatric Social Workers	0	3	3
Medical Officers	0	10	10
Medical Assistants	5	5	0
Records Dept. Workers	6	12	6
Receptionists	8	8	0
Security Workers	10	50	40
Sanitation Workers	10	30	20

incident involving a worker being injured or killed by a patient per year. While some nurses declared that a patient killed another nurse early in 2011, Dr. Osei said that the most recent incident was someone who was blinded in one eye after being hit by a patient. Many of the staff is forced to work at the hospital through either a nursing program or the national service requirement. The staff is terribly limited due to a combination of factors revolving around money and stigma. There are poor working conditions and the little pay reduces any incentive. For a 600-person workforce there are only 28 accommodation units, so most employees are dissuaded because they have to find their own housing closer to the hospital, or pay for transportation into the workplace from their home. As a result, many nurses have confirmed interest in moving to a different country in order to work in a more amicable and rewarding environment, which would further diminish the number of psychiatric nurses the Health Ministry has managed to train.

In 2010, the staff strength of Pantang Hospital numbered 524, with two psychiatrists, one clinical psychologist, three medical assistants, three pharmacists, 260 psychiatric nurses, two welfare officers, 34 ward assistants, one biostatistician, one biomedical scientist, eight occupational therapists, and zero occupational therapists. Dr. Dzadey suggests that the minimum number of psychiatrists the hospital should have is five, around one psychiatrist per two wards and one in OPD, but ideally, the number should be ten so that each ward has its own psychiatrist. In order to gradually reach that ten, the hospital can aim for five permanent psychiatrists and five training or rotating psychiatrists. The one present clinical psychologist overwhelmingly offers counselling, family therapy, individual therapy, and behavioural therapy to all of the hospital's outpatients and inpatients. Due to this unfathomable ratio of one psychologist to around 17,265 patients, the quality of therapy and frequency of contact is low, and Dr. Dzadey proposed that there should be a minimum of three clinical psychologists. Preferably, there should be one in every ward, and one in the outpatient department, which would add up to an idyllic number of 10 clinical psychologists. Dr. Dzadey commended the use of physical therapy and recommends that the hospital should also hire at least four physical therapists;

Table 9: Current and ideal staff strength of certain positions at the Pantang Hospital in 2011.

Occupation	Current Number	Number Needed	Gap
Psychiatrists	2	10	8
Clinical Psychologists	1	10	9
Physical Therapists	0	4	4
Occupational Therapists	0	3	3
Pharmacists	3	4	1

currently, there is none. Ghana's only occupational therapist retired two years ago, but luckily, a temporary occupational therapist came from VSO, Voluntary Service Overseas, and helped train some future occupational therapist assistants to continue her year-long work. However, there should be at least three permanent occupational therapists. The two welfare officers in charge of tracing and contacting the families of patients and organizing repatriation with appropriate CPNs are also severely overworked, which leads to patients staying longer than expected. Dr. Dzadey advises that there should be a minimum of one nurse to five patients. This would result in an average of 275 psychiatric nurses working solely in the wards whereas there are only 260 currently working in either the wards, psych OPD, and/or general OPD. Table 9 shows a clearer representation in the gaps of human resource at the hospital.

A person with an acute case is expected to stay at the Accra Psychiatric hospital for two weeks but usually ends up staying for one to three months, while a person with a major case usually stays for about two years though some stay for twenty or thirty years. Inpatients stayed at the Pantang hospital for an average of 63.2 days while vagrants, geriatric patients, and paupers lived in the wards for an average of 173.9 days. These hospitals have a problem with patients overstaying their welcome because there is not enough manpower to frequently evaluate each patient's progress, the courts do not come for them, or the patients live very far from the hospital. In some cases, the families forget to inquire about their relatives or refuse to pick them up due to the hospital's distance from their village, or the families can no longer be reached (sometimes due to a purposefully bogus address given during admission). Moreover, the associated stigma results in a great deal of patients being abandoned by their families upon admittance into the psychiatric hospital. A heartbreaking pattern common to the children's ward is parents giving spurious phone numbers and addresses to the hospital so that they can no longer be contacted in reference to their child. On average, only 20% of patients at the Accra Psychiatric Hospital have relatives who care enough to occasionally visit and how they are doing; this mainly occurs for those suffering from minor cases.

For many years and still to this day, countless Ghanaians believe that supernatural, evil forces or spirits, bewitchment, or planted juju cause mental illness. The executives of MindFreedom find that most Ghanaians believe that the mentally ill cannot be productive in a society and that the reason they are mentally ill is because they are cursed or have offended a deity. The three noted that this perception cuts across all levels of age, education, and location. This assumption varies little between age and inhabited region, but sometimes varies in education level, with less schooled individuals often placing more blame on

supernatural forces while the more educated tend to hold more positive attitudes towards the mentally ill (Barke et al. 2010). Ignorance leads to stigma, but with increased education and awareness, more are starting to be receptive of the fact that it is a general disease. Ghanaians, and most people in the world for that matter, view mental illnesses differently than physical illnesses because physical illnesses are tangible, easy to comprehend, and are generally easily treated with the right medication. People are more likely to attribute supernatural causes to things they do not understand. The average Ghanaian view is the same for both the mentally disabled and the mentally ill. Though epilepsy is a neurological condition and not a mental illness, people with epilepsy are also considered to be mentally ill in Ghana because they share the same stigma and because they have been historically treated by psychiatrists due to the lack of neurologists.

The common Ghanaian perception of mental illness is changing. It was very troublesome for someone who was mentally ill, or related to someone who was mentally ill, to be married some time ago when families ran heritage checks for eligible bachelors or bachelorettes to be arranged in marriage. Now that families are becoming more independent and nuclear and the Western importance of romantic love is becoming a driving factor in marriage, a person who was mentally ill will no longer be completely disregarded as a potential mate. Also, in order to vote or become president it is written in the constitution that you “should be of sound mind, which becomes misinterpreted as denying the right to vote to anyone who has ever had a mental illness. There are many other unwritten rules that prevent the mentally ill from attaining full access to human rights. For example, a person might be evicted from an apartment if the property owner finds out that the person has, or has had, a mental illness. Although you would not be asked whether you have ever had malaria or AIDS at a job interview, it is commonplace in Ghana to ask if you have ever suffered from a mental illness, which then becomes viable grounds for being denied the job. You can also be fired or denied a promotion if a co-worker discovers that you had or have a mental illness, though another random reason for dismissal is usually given. The environment in education is also not conducive to people with mental illness. Although there is no policy that denies access to school, the attitude and stigma held by peers and faculty often leads a mentally ill person to drop out of school. Up until three years ago, if there was an international event or conference planned, it was common practice for police to round up all of the wayfarers on the main streets and dump them at the psychiatric hospital or on the outskirts of town. Fortunately, MindFreedom and BasicNeeds spoke against this inhumane action and it has not occurred since.

Due to a plethora of challenges the countries have to face, mental health in Africa is largely marginalized. Most African countries do not have mental health laws and the others have out dated, forty to fifty year old laws that were written when human rights were not an issue. On a scale from one to ten, Dr. Osei rated the quality of mental health care in Ghana as a four. All hospitals in Ghana are underfunded with 94% of the budget being spent on paying the necessary salaries of medical professionals and the remaining 6% going into running the hospitals. On average, the government allocates mental healthcare with 2.58% of the total health budget which is strictly limited to finance just the three psychiatric hospitals and not community care [6]. The funding by the Ministry of Health has been unstable since 2003 because psychiatric care does not appear to address urgent, life-threatening issues. The funding is not

based on needs but rather on limits set by the Ministry of Finance. Politicians in Ghana do not want to give attention to mental illness, a sickness with low morbidity, when high fatality conditions grab more national and international attention. Because of this and its stigma, mental health care receives little donations from charities. Amegatcher, Adico, and Taylor respectively rated the quality of Ghana's mental health care on the same scale as a four, two, and five. These low scores were supported by the lack of resources and funding available to psychiatric hospitals and the lack of priority in the government's agenda. The belief in superstition also deprives the mentally ill in Ghana of sympathy and compassion. This combination of ignorance yields the mentally ill vulnerable to suffering human rights abuse, leading to Dr. Osei's low rating. Fortunately or unfortunately, Dr. Osei believes that Ghana's mental health care system is one of the best in West Africa besides maybe Nigeria.

Impending Changes

Instead of facily increasing the number of psychiatric hospitals in Ghana, Dr. Osei wants to create 20-bed psychiatric wings in every regional hospital and 12-bed wings in every district hospital. Right now only five of ten regional hospitals have 20-bed psychiatric wings. General medical practitioners should also start receiving some training in psychiatric care so they can better treat their patients and discern when to refer them to a psychiatrist if necessary. The Chief Psychiatrist also wants to downsize the three psychiatric hospitals, ultimately changing Accra Psychiatric Hospital's admittance from 1,200 to 300 patients, Pantang from 500 to 200, and Ankaful from 300 to 100 in-patients. The downsizing of the large hospitals and the creation of small wings throughout the whole country will deinstitutionalize the mental health care system in Ghana so it can ultimately focus on community care.

Dr. Osei finds that many Ghanaians now believe that mentally ill patients can lead a happy, healthy life after treatment, but still there are only two rehabilitation services in all of Ghana that help reintegrate mental patients into society. These facilities are run by Catholics in Kumasi and discharged patients who permanently live near the Ashanti Region are sent there after treatment to learn some trade. Dr. Osei recommends that these services should be replicated and that there should be at least one rehabilitation resource in every region.

The Pantang hospital would like to establish a Half-Way home for rehabilitation of chronic patients (a proposal has been sent three different times but it still has yet to be approved), start a fishpond rehabilitation project, develop an addiction outpatients clinic hot line, equip the laboratory, records, and pharmacy departments with a software, utilize a computerized data system, create a web page, expand a Drug Rehabilitation Centre, build more staff accommodation units, ensure accessibility to needed medications at the pharmacy, increase security, focus on prevention, recovery, and relapse-reducing programs and activities, and enhance staff morale by providing better incentives, training, equipment, and uniforms. The Pantang Hospital is also working on a proposal to create an evaluation ward which would help to avoid long-stay patients and streamline the diagnosis and welfare process. In this ward the patients would be observed for a maximum of 72 hours by a specialized screening team in order to make sure the patients' diagnoses are correct and that they require admittance into the hospital.

The most recent mental health law, written in 1972 when international human rights was not much of a concern, also needs to be updated. Both the Chief Psychiatrist and MindFreedom were involved in the drafting and advocacy of the new Mental Health Bill. The bill will address a lot of setbacks in the mental health system. If passed, the Mental Health Bill will commit the government to release more funds and resources for mental health care (to 8% of the health budget), train more mental health personnel including psychotherapists and counsellors, give incentive (salary, insurance, benefits) for people to work in mental health care, provide newer generation medicine, overhaul and decentralize the hospital-based system and make mental health care more community based, create an anti-stigma and education campaign, and protect the human rights of the mentally ill. Right now there are no checks for human rights abuses of the mentally ill, and this bill will make it illegal to put the mentally ill in chains and a new standard committee will work closely with prayer camps to oversee and enforce the upholding of all human rights. All in all, the Mental Health Bill will ensure effective treatment for the mentally ill and the law will serve as a standard for other African countries to follow.

The bill was submitted in 2006 and did not reach parliament until the end of 2010, where it is sitting to this day. It took four years before the government bothered to address the situation simply because they did not value the issue. Mental illness is such a low priority for the government because of the stigma that exists even in the minds of politicians and because mental health disorders have a low fatality (only 15–20 patients died in 2010 at the Accra Psychiatric Hospital). Though mental illnesses do have a low morbidity, mentally ill people experience many years living with pain, stigma, lifestyle changes, complicated therapeutic regimes, the long-term threat of decline, and shortened life expectancy [14]. With a lack of general funding for healthcare, more money is given to high fatality, international attention-grabbing physical diseases like malaria, AIDS, TB, cancer, etc. Now, after the advocacy from doctors and NGOs bombarded the media, the Ministry of Health is finally being forced to change their stance on mental health care. The Parliament is currently conducting consultations and is reviewing the bill to guarantee that fragmentation of the mental system is what is best for Ghana. Mind Freedom and Dr. Osei hope that the bill will be passed by June 2011, and if it is not, then Dr. Osei flipantly said he will personally march all of his patients at the Accra Psychiatric Hospital down to the Parliament building to fight for their rights.

Dr. Osei hopes that the long struggling advocacy for mental health improvement will not lose steam and keep pushing until the bill is passed and even after to ensure the implementation of the law. Immediately after the bill is passed, he advises that a mental health board needs to be established with the purpose of overseeing the implementation of the bills requirements and the training of judiciaries, policemen, mental health personnel, nurses, and traditional faith healers in the law's policies. He wants Ghana to have state-of-the-art mental health care which delivers care to the doorsteps of every Ghanaian, provides a wide range of medicine, is part of the national health insurance scheme, employs mental health personnel of various categories, and is adequately funded and operated by motivated leaders and supported by research and evidence-based data. This could be achieved by having one of the best mental health laws in the world and by removing the emphasis from hospital based care to community care.

Similar to Dr. Osei, MindFreedom thinks that Ghana's mental health system should change from institutional care to community care. The hospitals should be decongested, CPNs should be given transportation to move between communities, newer medication should be used, and mental health workers should be given more incentives and should be covered by insurance. Most importantly, psychiatrists need to more frequently go into the community, human resource needs to increase, and medication needs to be more available. Also, the perception of mental illness needs to be worked on. Stigma makes the situation drastically worse and makes people less likely to seek treatment even when it is important to seek early treatment so the problem does not aggravate.

Progress

Despite the Accra Psychiatric Hospital's disturbing conditions and appalling lack of resources, Dr. Osei's undaunted and resolute passion for mental health is leading the country towards progress. In the beginning of 2011, Dr. Osei launched a repatriation of 600 recovered patients, whose families could be tracked down, to be discharged and returned home. Dr. Osei oversees each case to make sure that each discharged patient is well enough to go home and that they have a family or home to return to. So far the repatriation has been successful in decongesting the hospital, as 200 patients have been discharged by March 2011 and the total of 600 is expected to be achieved by June 2011. If the hospital does reduce its capacity to 600 inpatients by the summer, then it is well on the way to reaching the ultimate downsizing goal of 300 inpatients, what Dr. Osei wants most to happen for his hospital. Upon hearing news of the repatriation, more families are inquiring about the possibility of picking up their once abandoned relatives. Social welfare workers and CPNs are in charge of bringing the patients back home safely.

MindFreedom Ghana fully supports Dr. Osei's repatriation of patients. They trust that sending patients back into society will help lower the stigma of mental illness by making their families reaccept them and by showing the public that survivors can become productive members of the community. Right now MindFreedom is searching for someone to fund a project that would help teach, empower, and rehabilitate the patients who are being sent home. The repatriation is noted as a sign of improvement in the mental health care system and MindFreedom thinks that the decongestion act should be replicated by the Pantang and Ankaful hospitals.

MindFreedom believes that Dr. Osei and Dr. Dzadey have a lot of energy and passion for the mentally ill and are doing the best they can with the resources available. Despite challenges, many achievements have been accomplished by Dr. Dzadey and the Pantang Hospital. In 2007, a revenue-producing Rehabilitation Vegetable Garden opened and is now tended to by patients and national service personnel who have a background in agricultural science. In 2009, a Drug Treatment and Rehabilitation Unit was created and in 2010 it was recognized by the World Federation of Therapeutic Communities. It is totally inappropriate to group addicts with other mentally ill patients, seeing that drug abusers who do not consider themselves mentally ill will steer clear from entering psychiatric hospitals. Because of the initial lack of focused addiction counselling, users would often return to the hospital shortly after they were discharged. Henceforth, this Drug Rehabilitation unit was the first step taken

to take care of addictions separate from the mainstream patients in the wards. Addicts pay to reside at the hospital and partake in this structured 6 am–10 pm program at the Drug Rehabilitation Centre, where they receive therapy from a well trained staff for a minimum of six months. Occupational therapy assistants involved in VSO now help assess the therapeutic needs of the patients, teach bead making, and collaborate with the wards. A nursing assistant even started an initiative for engaging the patients in physical activities and successfully organized a weeklong inter-wards sports competition a year ago that was well received by both staff and patients. Also, the general supply of new generation anti-psychotics improved and two boreholes were built by the National Security office to help create an independent water supply in 2010.

Awareness, stemming from mental health workers and the birth of mental health NGOs, is undeniably increasing. Before the year 2000 there were no NGOs in Ghana that directly focused on issues in mental health, and now there are at least six very active ones. BasicNeeds, MindFreedom, Psycho-Mental Health Foundation, the Mental Health Society of Ghana, and the Ghana Mental Health Association are the most prominent. Still, the number of NGOs for mental health is miniscule compared to the number of NGOs for malaria and AIDS. The media also began getting engaged with the movement towards improvement of mental health when journalists became more radical rather than being obsequious to the government. With the help of NGOs, the media, and certain mental health professionals, the National Development Planning Commission of Ghana finally adopted mental health as a developmental agenda for 2010–2013.

MindFreedom, one of the Mental Health NGOs, began in the home of Director Janet Amegatcher in 2004 with Nii Lartey Adico as Co-Director and Dan Taylor as Executive Secretary with the mission to advocate for the rights and dignity of persons with mental disabilities in Ghana. The three were each personally affected by mental illness either directly or through a close relative. All of the three were so dismayed by the callous popular opinion and the condition of the psychiatric hospitals that they searched for a way to educate and sensitize the Ghanaian public. Originally the NGO was funded by the World Health Organization but is now funded by America's international Disability Rights Fund. In July of 2008, the company moved into a permanent building in Osu, Accra and is open for counselling during normal working hours. The director is trained in counselling and MindFreedom has both a clinical psychologist and a psychiatrist as board members who are utilized for referrals. The NGO also puts on advocacy and awareness events in Accra about twice a year.

For three years, MindFreedom has organized annual street marches through popular roads in downtown Accra, the most recent being in 2010 with 700 participants, in order to fight mental health stigma and to bring attention to the Mental Health Bill and the UN Convention on the Rights of Persons with Disabilities. They try to change perception through education by discussing mental health issues on the air, radio, and newspapers and by posting small posters and stickers around the city. The NGO also puts on training workshops for journalists, judges, lawyers, the police, prison service, and other workers who have direct or indirect contact with the mentally ill, to teach them about how to appropriately deal with the mentally ill and to educate them on current policies. Currently MindFreedom Ghana has 154 members, either mentally ill or survivors of mental illness, most of whom have now luckily stabilized enough to

return to work. Because of funding and the price of transportation, the members can only meet every three months to discuss their issues and their progress. MindFreedom is now submitting a proposal for a three year reintegration and rehabilitation program to help those discharged from the psychiatric hospitals.

The mission of BasicNeeds, a worldwide mental health NGO, is “to initiate programmes in developing countries which actively involve mentally ill people and their carers/families that enable them to satisfy their basic needs and exercise their basic rights [6]. Under the management of Badimak Peter Yaro, BasicNeeds Ghana was established in 2002 with the purpose “to enable people with mental illness and epilepsy to live and work successfully within their community [6]. Over the past nine years, BasicNeeds Ghana has affected the lives of 18,838 sufferers of mental illness or epilepsy, and 17,603 of them are still receiving regular treatment and counselling thanks to the NGO. BasicNeeds has helped create 182 community self-help groups for the mentally ill and their primary carers. The NGO has trained or is currently training 4,681 beneficiaries in some form of vocational training while also hosting several public awareness events a year. In the winter of 2010, a march took place in the Upper East Region of Ghana for the celebration of the World Mental Health Day, a community durbar was held in Accra in order to increase awareness of Self-Help Groups for people with mental illness and epilepsy, and a photo project took place in 12 different districts to visually capture the conditions the mentally ill people live in. Most importantly, BasicNeeds puts on quarterly community outreach clinics in the north of Ghana, specifically in poor communities in the three northern regions where there is no permanent psychiatrist. The most recent clinic, in the last quarter of 2010, reached 155 mentally ill people from five districts in the Upper West Region. BasicNeeds strongly believes in community care and has helped many mentally ill people gain access to professional treatment [6].

Through funding from the European Union’s project “Ensuring Secure Livelihoods for Poor Mentally ill People and their Primary Carers in Ghana, BasicNeeds organized a secure livelihoods module and assists CPNs and self-help groups in the assessment of skills priority and livelihood options of stabilized members who are then subsidized by the specific group they belong to [6]. Common livelihood options and skills priorities users pursue include farming, animal rearing, grain storage and sale, petty trading, food processing, tailoring, hairdressing, weaving, and bicycle repairs. This sustainable project encourages social, human, and economic development, while positively changing the attitude regarding the mentally ill and their carers by showing the society that they can be productive [6].

Over the past two years, BasicNeeds has conducted one to two day workshops on procedural and financial training for self-help groups, epilepsy training for medical practitioners, mental health training for master craftsmen arranged to teach skills to the mentally ill, mental health training for Agric Extension Workers who have contact with mentally ill workers on farms, and policy and human rights training for security officers in the Ghana Armed Forces, Ghana Police Service, Ghana Immigration Service, Ghana Prisons Service, Customs Excise and Preventive Services, Ghana National Fire Service, City Guards Unit of the Tamale Metropolitan Assembly Task Force, and Bilchinsi Taskforce. A quiz competition with questions on various aspects of mental illness also took place between four Junior High Schools in Tamale and was broadcast on the radio. In addition, BasicNeeds Ghana conducted research on mental health fi-

nancing, lobbied Ghana's Parliament to promote a speedy passage of the Mental Health Bill, and helped build a multipurpose psychiatric facility in the Upper West regional capital, Wa, with the help of Ghana Health Services and three other charities [6].

The past ten years have seen the most significant increase in awareness of mental illnesses, which MindFreedom attributes to the birth of mental health NGOs. The first street march MindFreedom organized in 2006 presented neatly dressed, seemingly normal mentally ill patients and survivors, which subsequently shocked citizens and helped bring media attention to the plight of the mentally ill. When the executives were younger, mental illness was not talked about and one of the executives mentioned that he fearfully walked on the other side of the street when passing by the psychiatric hospital to avoid the mad people and the evils associated with them. Anyone seen walking into the psychiatric hospital also became the talk of the town in a negative way. MindFreedom dreams that Ghana will have mental health care as reliable as in the West in regards to human rights, access to treatment, and access to medication. They want everyone to know that anybody can be stricken by a mental illness, and they kept mentioning a proverb: "You shouldn't wash your dirty linens outdoors, but if you keep them inside, the room will stink. By this they meant that families should not keep their disabled ones hidden in a room but should bring them out and not be ashamed of them.

Discussion

Like in most developing countries, access to mental health in Ghana, where schizophrenia, depression, alcohol and cannabis abuse, and epilepsy are the most common diagnoses, remains low because of the limited number of treatment centres and the high mental patient to mental doctor ratio. Due to the discriminatory stigma, the low fatality of mental illness, and the alleged significance or discrepancy of physical health over mental health, the government in Ghana holds mental illness as a very low priority even though it is a leading component of the global burden of disease. The lack of priority lead to insufficient funding and outdated mental health policies which in turn caused a severe lack of mental health personnel and incentives to gain personnel, low employee morale, shortages of psychotropic medicine, human rights violations, congestion of institutionalized hospitals, poor condition of decaying facilities and inadequate equipment, lack of community care, lack of preventative and rehabilitative services, absence of research-based evidence, and the lack of an aggressive education and awareness campaign. All of these challenges need to be addressed in order to decrease the number of relapses and increase prevention and the rate of recover but unfortunately mental health professionals are often too busy to lobby for the implementation of change. Most importantly the psychiatric hospitals need to be decongested, the mental health staff strength needs to increase, community care and rehabilitation needs to be emphasized, and the Mental Health Bill needs to be passed.

Despite Ghana's challenges, much progress has been displayed through MindFreedom and BasicNeeds' community and awareness work, Dr. Dzadey's implementation of therapy and creation of the Drug Rehabilitation Unit, and Dr. Osei's repatriation of the Accra Psychiatric Hospital. Though MindFreedom

commended the repatriation of patients, BasicNeeds is arguing that there should have been a half-way home or reintegration centre set up to prepare the patients, who might have spent 20 or more years at the hospital, to live an independent life before being returned home. That would have been ideal; however, it is unrealistic because it would have taken a long time to create the rehabilitation centre and the hospital needed to be decongested as quickly as possible. The Castle Road Special School, built in 1968 and directed by Isaac Ben Roosevelt Gadoter, is the only special needs school in Ghana that is located in a Psychiatric Hospital. The school provides hands-on therapy, art, reading, music, outdoor activities for the mentally ill or disabled in the Children's Ward at the Accra Psychiatric Hospital. The teachers there represented one of the very few instances when I saw true compassion for the mentally ill/disabled during my time in Ghana and one of the even rarer instances when I heard that someone loved their occupation at the psychiatric hospital. After volunteering at another special needs school for children with autism, learning delays, hearing and speech problems, SENCADRAC, I luckily witnessed even more sympathy and care for the unique children in Ghana. There are 14 other registered special needs schools in Ghana, and they are at the forefront of displaying empathy for the mentally ill and disabled in the country. Hopefully, this sympathy will spread to mainstream schools and then to the entire public.

The infrastructure of mental health services is reliant on satisfactory funding and allotting sufficient finances to allow for the delivery of notable mental health services, the effectual training of staff, and the development of collaborations and consultations which will make mental health service much more accessible. Though the health sector in general is underfunded, it is imperative that the Ministry of Health allocates funding to community mental health care and that the financing of the psychiatric hospitals becomes based on need, rather than unjustified ceilings, due to the vulnerable nature of the mentally ill. The Mental Health Bill will guarantee that at least eight percent of the total health budget (compared to the current 2.58%) will be apportioned to mental healthcare.

The government is responsible for addressing the needs of its citizens by formulating suitable legislations and the Mental Health Bill offers the government a chance to enhance the delivery and accessibility of mental health services. The World Health Organization is calling the bill one of the best mental health laws in the developing world and believes that when it is passed it can serve as a model for other countries [12]. The bill needs to be passed in order to avoid the collapse of a currently unstable mental health care system.

The Mental Health Bill, Dr. Osei, MindFreedom, and BasicNeeds all promote the extension of psychiatric services into community district and regional hospitals. Integrating mental health services into primary care has shown to be more cost effective than institutional care [6]. This integration will also help improve access to mental health services in remote areas where patients presently travel a great number of miles for psychiatric treatment. Currently, care is mainly restricted to the institutional administration of psychotropic drugs instead of preventative or rehabilitative psychosocial interventions, due to the dearth of allied mental health personnel (i.e. occupational therapists, psychiatric social workers, psychologists) and the limited number of community psychiatric nurses [2]. An accelerated, specialist training program should be locally established in order to increase the number of allied mental health personnel. The problematic brain drain of staff could be alleviated by providing satisfactory

remuneration and incentives to encourage trained personnel to stay in Ghana or to return home from overseas.

If a mental illness goes untreated, there are three possible consequences for the victim. The first is living with the sickness and underachieving or having low productivity because the person is not performing properly or to their highest potential. Secondly, the untreated person could engage in social vices such as drugs, armed robbery, and paedophilia. The third possibility is to die from complications of the illness, i.e. committing suicide due to depression, engaging in risky activities due to bi-polar disorder, not eating because of schizophrenia, or dying from a tumour that initially caused the illness. Each day that the bill remains before Parliament, Ghana is officially allowing the rights of the vulnerable to be abused by placing patients in overly congested institutions with little doctor-patient contact.

A society of acceptance makes a much more favourable environment for recovery from mental illnesses, with stigma representing a large barrier to recovery [8]. Even in developed countries, people who are misinformed about mental illnesses can respond negatively to a friend or relative's mental illness. Mental illness is not caused by poor decisions or by offending the gods, but can affect anyone no matter what ethnicity, background, age, or gender. The mentally ill can benefit from psychotherapy, group therapy, medication, self therapy, rehabilitation, and the acceptance and understanding from friends and family. Programs that encourage understanding and awareness of mental health issues and demystify mental illness should be forcefully undertaken for communities to further tolerate and acknowledge the mentally ill. Overcoming these widely prevalent traditional myths on mental illness will help lead more patients to seek professional treatment early on [9]. Public health officers and the health promotion unit should integrate mental health into their awareness and advocacy programs [1]. Mental health needs to be recognized and integrated into both primary and secondary care, social and health policy, and health system organization [14].

The delivery of mental health care can also be improved by concentrating on currently active programs dealing with the prevention and treatment of tuberculosis, malaria, HIV, domestic violence, and maternal care. This should spark the interest of the government because advancing the mental health system could help the country reach the Millennium Development Goals which address HIV/AIDs, malaria, tuberculosis, child mortality, maternal health, and the empowerment of women. It has been consistently reported that HIV is associated with poor mental health due to psychological trauma and the causing of neuropsychiatric complications such as depression, cognitive disorder, mania, and dementia due to effects on the central nervous system. Strong evidence from developed countries also shows that depression, alcohol and substance abuse disorders, and cognitive impairment negatively affect adherence to antiretrovirals. In the US, those treated for depression for six months showed improvement in HAART adherence compared to those who did not take antidepressants. Some studies have also shown that the incidence of tuberculosis infection is high in people with serious mental illnesses or substance use disorders. Heavy drinkers had double the risk of being infected with tuberculosis compared to non-drinkers, according to a study in the US. Though there is little evidence, depression might also cause low adherence to anti-tuberculosis medication, which makes it very difficult for a country to control the disease. With gynaecological health being

greatly affected by depression, anxiety, sexual and domestic abuse, and substance and alcohol use, many studies have also linked reproductive morbidity with mental illnesses. Depression is more common among women, especially poor women, due to domestic violence and lack of autonomy. Maternal psychosis increases the risk of infant mortality while maternal schizophrenia can result in low birth weight or premature delivery. Postpartum depression also leads to poor mother-infant interaction and little devotion to the health of the child [14].

Mental disorders increase the risk for transmission of infectious disease and the development of non-communicable diseases and communicable diseases, while other sicknesses increase the risk for mental illnesses. Because of this co-morbidity, mental health policies should be integrated into different levels of care, with primary care physicians trained in treating mental disorders. Current community and public health programs or campaigns should become familiar with mental disorders in order to help improve both the physical and mental health of their targeted patients, which will lead to quicker recoveries. If general physicians and prominent health-related NGOs start to increase awareness and encourage or participate in the treatment of mental disorders, a great deal of pressure will be taken off of the limited mental health staff in Ghana [14].

Limitations

I was planning to interview BasicNeeds but ran out of time and found sufficient information from their most recent publication. Due to time constraints and the busy nature of Dr. Dzadey's occupation, I was unable to ask her opinion on the manner of which Ghana treats its mentally ill. The language barrier made it difficult to potentially interview any mentally ill patients, though it would have added greatly to my report. My lack of knowledge in psychotropic medicines made the intention to interview a psychiatrist somewhat trivial. I was unsuccessful in finding the contact information of bureaucrats and any officials in the Ghana Health Service, so I was unable to interview people involved in the policy making behind mental illness. WHO did not respond to my requests.

Acknowledgements

I would like to thank Dr. Akwasi Osei, Dr. Anna Dzadey, and MindFreedom for allowing me to interview them, and UC-EAP and Dr. Adote Anum for supervising my special study project. Most importantly I want to thank my mother and financial aid for funding my travel and research in Ghana.

References

- [1] Asare J (2003). Mental Health Profile (Ghana). World Health Organization African Region: Ghana.
- [2] Awenva AD, Read UM, Ofori-Attah AL, Doku VC, Akpalu B, Osei AO, Flisher AJ; MHaPP Research Programme Consortium (2010). From mental health policy development in Ghana to implementation: What are the barriers? *African Journal of Psychiatry* (Johannesburg) 13, 184–91.
- [3] Barke A, Nyarko S, Klecha D (2010). The stigma of mental illness in Southern Ghana: attitudes of the urban population and patients' views. *Social Psychiatry and Psychiatric Epidemiology*.
- [4] BasicNeeds (2007). Demographic and economic characteristics of people with mental illness: a study in Ghana. Principal Investigator: Shoba Raja.
- [5] BasicNeeds (2007). Mental illness and economic well being: a study in Ghana. Principal Investigator: Shoba Raja.
- [6] BasicNeeds (2010). Share Learn Share: BasicNeeds Newsletter Issue 1.
- [7] Central Intelligence Agency (2011). The World Factbook: Africa: Ghana. <https://www.cia.gov/library/publications/the-world-factbook/geos/gh.html>
- [8] Bird P, Omar M, Doku V, Lund C, Nsereko JR, Mwanza J, the MHaPP Research Programme Consortium (2010). Increasing the priority of mental health in Africa: findings from qualitative research in Ghana, South Africa, Uganda and Zambia. *Health Policy Plan*.
- [9] Ewusi-Mensah I (2001). Post colonial psychiatric care in Ghana. *Psychiatric Bulletin* 25, 228–229.
- [10] Laugharne R, Bums T (1999) Mental health services in Kumasi, Ghana. *Psychiatric Bulletin* 23, 361–363.
- [11] Omar MA, Green AT, Bird PK, Mirzoev T, Flisher AJ, Kigozi F, Lund C, Mwanza J, Ofori-Atta AL, Mental Health and Poverty Research Programme Consortium (MHaPP) (2010). Mental health policy process: a comparative study of Ghana, South Africa, Uganda and Zambia. *International Journal of Mental Health Systems* 4, 24.
- [12] Osei A (2008). Pass the mental health bill now. Chief Psychiatrist of the Ghana Health Service. Graphic Ghana.

-
- [13] Patel, Kleinman (2003). Poverty and Common Mental Disorders in Developing Countries. *Bulleting of the World Health Organisation* 81, 609–15.
 - [14] Prince M, Patel M, Saxena S, Maj M, Maselko J, Phillips MR, Rahman A (2007) Global mental health: no health without mental health. *The Lancet* 370, 859–77.
 - [15] World Health Organization (2002) Nations for Mental Health: Final Report. Mental Health Policy and Service Development: Department of Mental Health and Substance Dependence, WHO Geneva.
 - [16] World Health Organization (2007). Ghana a very progressive mental health law. Mental Improvements for Nations Development: Department of Mental Health and Substance Abuse, WHO Geneva.