Implementation of the Mental Health Act in Ghana: A study of barriers and enablers using a mixed-method approach

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STATEMENT OF ORIGINALITY

I hereby certify that the work embodied in the thesis is my own work, conducted under normal supervision. The Thesis contains no material which has been accepted, or is being examined, for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made. I give consent to the final version of my Thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968 and any approved embargo.

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DEDICATION

To my beloved family who endured my intermittent absence for nearly 4 years. The work is also dedicated to God Almighty for the guidance, and for granting me knowledge and good health to complete the programme.

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ABBREVIATIONS

CHRAJ	Commission for Human Rights and Administrative Justice
CPO	Clinical Psychiatric Officer
DACF	District Assembly Common Fund
DFID	Department for International Development
DHIMS-2	District Health Information Management System
DALYs	Disability Adjusted Life Years
DOVVSU	Domestic Violence and Victim Support Unit
GFD	Ghana Federation of Disability Organisations
GHS	Ghana Health Service
GMHA	Ghana Mental Health Authority
GSS	Ghana Statistical Services
HMRI	Hunter Medical Research Institute
KHRC	Kintampo Health Research Centre
KHDSS	Kintampo Health and Demographic Surveillance System
LEAP	Livelihood Empowerment Against Poverty Program
LHPS	Learning Health Policy System
LI	Legislative Instrument (LI)
LMICs	Low and middle-income countries
MHA	Mental Health Act
MLGRD	Minister of Local Government and Rural Development
MMDAs	Metropolitan, Municipal and District Assemblies
MOH	Ministry of Health
MoH	Ministry of Finance
NCCE	National Commission for Civic Education
NHIA	National Health Insurance Authority
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme
NIER	Newcastle Institute for Energy and Resources
NUPSA	Newcastle University Postgraduate Students Association
OECD	Organisation for Economic Cooperation and Development
PMD	Persons with Mental Disorders
REDCap	Research Electronic Data Capture
RHD	Research Higher Degree
RMHC	Regional Mental Health Coordinator

SDG	Sustainable Development Goals

ABBREVIATIONS Continued

SRC	Scientific Review Committee
SWCD	Social Welfare and Community Development
TFH	Traditional and Faith-Based Healing
TFHs	Traditional and Faith-Based Healers
UN	United Nations
UNCRPD	United Nations Convention for Rights of Persons with Disabilities
UoN	University of Newcastle
WHO	World Health Organisation
WHO-AIMS	WHO Assessment Instrument for Mental Health System
YLLS	Years of Life Lost

CONFERENCE PRESENTATIONS

Name	Date
31st Annual conference of the International Society for Environmental Epidemiology, Utrecht, The Netherlands.Title of poster presentation: Impact of prenatal maternal stress on birth anthropometrics and pregnancy outcomes in rural Ghana.	August 2019
2019 National Health Research Dissemination symposium. Making research drive innovation and progress towards UHC and the SDGs, GIMPA, Accra, Ghana. Title of oral presentation: Implementation of a Mental Health Act in Ghana: A study of potential barriers and enablers using a mixed method approach	June 2019
4th Mental Health and Well-being Conference of Ghana: Kwame Nkrumah University of Science and Technology, Kumasi-Ghana. Title of oral presentation: Implementation of the Mental Health Act in Ghana: A study of potential barriers and enablers using a mixed-method approach.	October 2018
4th Mental Health and Well-being Conference of Ghana: Kwame Nkrumah University of Science and Technology, Kumasi-Ghana. Title of oral presentation: Analysis of Service Provision for Mental and Neurological Disorders among Adolescents in two Districts of Ghana.	October 2018
Global Initiatives in Maternal Care – School of Nursing and Midwifery (Johnson et al.) Research Seminar, Callaghan, University of Newcastle, Australia. Title of oral presentation: Implementation of the Mental Health Act in Ghana: A study of potential barriers and enablers using a mixed-method approach.	August 2018
International Mental Health Day-Showcasing work done in Ghana at HMRI. Theme: Celebrating Ghana through the lens of mental health. Title of oral presentation: Implementation of the Mental Health Act in Ghana: A study of potential barriers and enablers using a mixed-method approach.	October 2017

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ABSTRACT

Background

The introduction of the Mental Health Act (MHA) 846 in 2012 to promote and improve mental health service provision has been recognised locally and internationally as an excellent step for transforming mental healthcare in Ghana. Despite some achievements resulting from implementing the MHA, there has been a weak implementation of the policy provisions similar to previous policies such as the 1888 Lunatic Asylum Act and the 1972 Mental Health Decree that were loosely implemented. Little is known about the main contextual issues that would facilitate or impede the implementation of the present MHA. The aim of this Thesis was to investigate the barriers and enablers to implementing the current MHA.

Methods

A mixed-method approach including a survey, focus group, interviews, and field observations were used to investigate the barriers and enablers to implementing the MHA. The study participants included senior civil servants, health professionals, law enforcement officers, parliamentarians, carers, community opinion leaders, mental health service users and traditional and faith-based practitioners. For the quantitative study, the World Health Organisation Disability Assessment Schedule (WHODAS-12, version 2.0) was used for data collection to measure level of functional disability among people with mental disorders. A study-specific survey was conducted to assess both participants' access to support from the available mental health stakeholders in Ghana and their knowledge of the MHA. For the qualitative study, in-depth interviews and focus group discussions were conducted with district, regional, and national key stakeholders. The qualitative data collected through interviews and focus groups were digitally recorded, transcribed verbatim and exported into NVivo 11 for analysis. Quantitative data were analysed using descriptive statistics, while thematic analysis utilising the 5-step Framework approach was used for analysing the qualitative data.

Results

This Thesis reports significant achievements in mental health service provision attributable to the influence of the MHA. Some of these notable achievements include: establishing the Ghana Mental Health Authority (GMHA); expansion of the mental health workforce through the appointment of regional mental health coordinators (RMHC) entrusted with the mandate to coordinate mental health services in the various administrative regions; and the provision of other mental health personnel that invariably increased access to mental health services.

Participants also reported that there had been a systematic reduction in the use of chains and flogging of people with mental illness to drive out evil spirits.

Thematic analysis identified five main barriers impeding the implementation of the MHA. These include: underfunding mental health due to a lack of political commitment; policy failure and delay in passing the Legislative Instrument (LI); insufficient resources and mental health workforce; poor mental health literacy and limited knowledge of the MHA and a lack of mental health data for planning. Participants reported that the insufficient allocation of resources for mental healthcare results in poor mental health service provision, which directly affects the implementation of the statutory provisions of the MHA. Some of the identified enablers for implementing the MHA include advocacy, central Government intervention through increased funding, and effective collaboration with Traditional and Faith-Based Healers (TFHs) through guidance and regulation to minimise human rights abuse.

Findings from this study showed that key stakeholders play a central role in facilitating the MHA implementation, yet no broader consultation and collaboration among stakeholders currently exist in efforts to implement the MHA. Stakeholders and key institutions such as the GMHA, Ministry of Health (MoH), Ghana Health Service (GHS), TFHs, National Health Insurance Authority (Igbinomwanhia et al.), District Assembly, Social Welfare, NGOs, health service providers, legal services including Ghana Police Service, Prison Services and Commission for Human Rights and Administrative Justice, community opinion leaders, service users and carers were identified as playing critical roles to ensure the MHA is implemented.

The quantitative study reports higher disability (66%) among participants with mental illness, indicating an inability to function well due to the mental disorder. Also, there was a general lack of a support network for people with mental disorders in the area, with only a third of the participants having access to any form of support or social protection services.

Conclusion

Key stakeholders' commitment to mental healthcare in Ghana is lacking, evidenced by the limited implementation of the provisions of the MHA. Integrating mental health in primary healthcare and collaboration between various healthcare providers could be an excellent strategy in harnessing and maximising the limited human and material resources and, more significantly, destigmatising mental illness. Government commitment and investment in mental healthcare will be significant in facilitating the implementation of the MHA provisions to ensure the desired improvement of Ghana's mental healthcare delivery.

Keywords: Mental Health Act (MHA), policy implementation, mental illness, barriers, enablers, mental healthcare, mixed-methods, Ghana

DEFINITIONS OF TERMS

The working definitions of the key terms used in this document are as follows:

Barrier: Anything which prevents, or limits, a given policy instrument from being implemented.

District Assembly: Is the basic unit of political governance at the district or regional level and includes municipal and metropolitan assemblies.

Durbars: Gathering of chiefs and people to discuss community development agenda

Enablers: Factors, forces, and resources that facilitate the successful implementation of a program.

Implementation: Roll out of the Mental Health Act since its introduction in 2012 in Ghana.

Mental disorders/illness: The WHO refers to mental illness as a diagnosable illness which affects a person's thinking, emotional state and behaviour, and disrupts the person's ability to work or carry out other daily activities and engage in satisfying relationships (DSM-V).

Mental Health Act/Law 846 (MHA): An Act of Parliament for the provision and regulation of mental healthcare and associated matters.

Mental health users: People living with mental disabilities otherwise referred to as mental health consumers in other jurisdictions.

Pastors: A minister in charge of a Christian church or congregation, especially in some charismatic or religious churches.

Persons with disabilities: These are people with long-term physical, mental, intellectual or sensory impairments which interact with various difficulties and may hinder their full and effective participation in society on an equal basis with others.

Policy: A statement of intent, or principles to guide decisions in order to achieve individual or corporate goals. A policy is implemented as a procedure or protocol.

Prayer camps: Non-governmental religious institutions for spiritual healing.

Severe mental disorders: These refer to severe disturbances in thinking, emotion, and behaviour. Examples include schizophrenia, major depression, and bipolar disorders.

Shrines: A sacred or holy place, that is dedicated to a specific deity, ancestor, god or a figure of awe and respect, at which people venerate or worship them.

Stakeholders: Relevant individuals or institutions (both public and private) responsible for playing an active role in mental healthcare.

Traditional Healers: Persons who use long established ‘Traditional’ methods to treat people suffering from various diseases, many of which have psychological underpinnings.

Traditional healing: The practice of using local herbs to treat diseases including mental disorders.

Chapter 1 Introduction

1.1 Background

This chapter introduces the extent of the burden of mental disorders globally and in Ghana in particular. The international context of mental healthcare with particular attention to mental health legislation in Ghana and Africa is presented. The chapter also discusses the history of mental healthcare in Ghana and the significance of this study in investigating the barriers and enablers for implementing the MHA in Ghana.

The primary goal of any mental health policy is to ensure that the rights of persons with mental disorders are protected through the provision of safe and effective mental healthcare (McGorry et al., 2014; Patel & Bhui, 2018). Although laws and policies for every domain of society are vital for peaceful growth and cohesion, people with mental disorders particularly need special attention because of their vulnerability to abuse, including stigmatisation and social rejection (Bartlett & Sandland, 2007; Faydi et al., 2011; Lund, Breen, et al., 2010). Mental health legislation provides a regulatory framework for providing mental health services and the protection of human rights (Saxena, Lora, et al., 2007). The mental health framework developed for Ghana directs procedures and measures for regulating how mental health services are provided, by whom and under what circumstances. The framework also addresses the need to protect the human rights and citizenship entitlements of those subject to the Act (Duffy & Kelly, 2017).

In 2012, the agenda for mental healthcare in Ghana saw a new and promising dimension with the introduction of a contemporary MHA (Act 846, 2012). The MHA was primarily in response to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) call for all nations to provide legislative protection for the rights of persons with disabilities. The World Health Organisation (WHO) supported the UNCRPD stating that all people with mental disorders have the right to receive high-quality treatment and care (Pathare, 2003). Despite the WHO stating that all people with mental disorders have the right to receive high quality treatment and care delivered through responsive healthcare services and be protected against all forms of inhuman treatment and discrimination (Pathare, 2003), it would appear that minimal progress has been achieved since the passage of the MHA nearly a decade ago.

Implementing mental health legislation in a country where safeguards have not previously existed may be a major challenge. Developing African countries face many health challenges, often resulting in mental health resourcing being a low priority (Eaton et al., 2011). Further to

this, the complex interface in developing countries between indigenous traditional beliefs, practices and biomedicine can result in poor mental health literacy and act as an impediment to the enactment and implementation of mental health legislation (Burns & Tomita, 2015; Green & Colucci, 2020).

1.2 The Republic of Ghana

Ghana is a Republic and is located in the western part of Africa, lying above the equator in the northern hemisphere. Situated between the eastern and western hemispheres, Ghana is bordered by Burkina Faso to the North, Cote D'Ivoire to the West and Togo to the East, and the Atlantic Ocean and the Gulf of Guinea to the South.

Formerly known as the Gold Coast, Ghana gained independence from Great Britain in March 1957, becoming the first sub-Saharan nation to break free from colonial and foreign rule. With an area of 238,533 sq km, Ghana's population is currently 30.8 million (Ghana Statistical Service, 2021). The dominant language is Akan (Antwi-Bekoe et al., 2009) with English being the official language. The major religions include Christianity, Traditional African and Islam. The current life expectancy is 64 years and 66 years respectively for men and women. The main economic activity in Ghana is agriculture which engages more than 40% of the working population. As the second-largest producer of gold in Africa and ninth-largest worldwide, Ghana's gold accounts for more than 95% of all mineral earnings yearly (Armah et al., 2016).

Ghana is currently ranked 139th on the league of countries by the United Nations (UN) Human Development Index released in 2016. As an alternative to the conservative measure of national development, the UN Human Development Index represents a broader definition of well-being and provides a composite measure of three basic human development dimensions - health, education and income (United Nations Development Programme, 2021).

1.2.1 Governance of Ghana

The Government of Ghana operates a decentralisation policy, where all the Ministries, Departments and Agencies established at the national level are also represented at the regional and district levels. There are 16 political, administrative regions in Ghana (Figure 1). The district level is the final geographical space where all the governance actors converge to bring to reality central Government policies, including those governing health (Local Governance Act 936, 2006). The decentralisation policy is entrenched in the 1992 Constitution of Ghana directed at transferring central Government power, resources and functions to the District Assemblies for the effective implementation of policies and developmental agenda (Government of Ghana Decentralisation Policy, 2010).

There are currently 260 districts and 16 administrative regions in Ghana. Governance at the district level is established by the Local Governance Act (Local Government Act 462, 1993 and amended to Local Governance Act 936, 2006). The Local Government Act makes provision for allocating 2% of the District Assembly Common Fund (DACF) to be made available for persons with disability. The goal of the DACF for persons with disabilities is generally to reduce poverty and improve quality of life. The core duties and responsibilities of the District Assemblies are contained in the Local Government Act 936 which includes the implementation of central Government policies in their respective jurisdiction. There has been a perennial lack of goodwill and interest by managers of the country towards persons with disabilities (Badu et al., 2018).

Chiefs and Queen mothers are essential stakeholders and play a significant role in decision making in the communities. Apart from playing the role of community representatives, these leaders influence socio-cultural and political perspectives because they are regarded as custodians of the land (Ahmed et al., 2018). For centuries, the Ghanaian chieftaincy system has existed and survived the pre and post-colonial institution of governance with judicial, legislative and executive powers (Boafo-Arthur, 2003). Generally drawn from the royal families, the Chiefs and Queen Mothers are seen as powerful positions for community empowerment and education, bringing social, economic and political changes in their communities (Asamoah, 2012; Asante et al., 2013; Dumouchelle, 2017; Knierzinger, 2011). These leaders act as gatekeepers and mouthpieces for their respective communities. They are agents for promoting general health activities in the communities and will likely be critical in mental health advocacy.

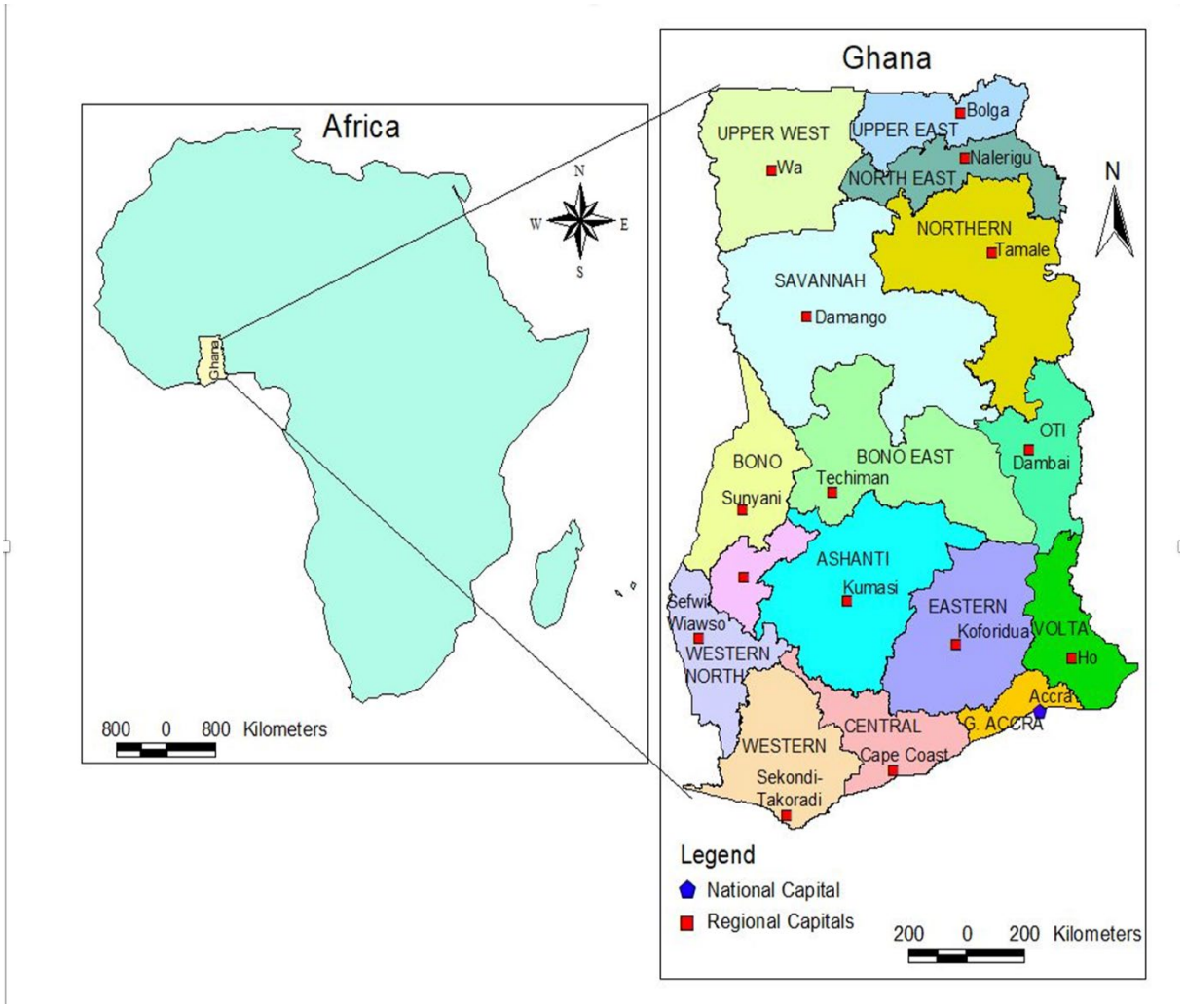

Figure 1: Map of Africa showing the location of Ghana and the 16 Administrative Regions

1.3 Global burden of mental disorders

The burden of mental health disorders globally underscores the importance of legislation in addressing health disparities and human rights abuses. The WHO estimates that more than 450 million (14% of the global population) people worldwide suffer from mental health disorders (World Health Organisation, 2013). The global effect of mental disorders is thus substantial, resulting in an estimated 7.4% of the world's measurable disease burden (Lozano et al., 2012). According to the Global Burden of Disease study, in 2010, mental, neurological and substance use disorders accounted for 10.4% of global Disability Adjusted Life Years (DALYs), 2.3% of global Years of Life Lost (YLLs) and, 28.5% of global Years Lived with Disability (YLDs), making them the leading cause of YLDs (Whiteford et al., 2016; Whiteford et al., 2015). Mental disorders accounted for the largest proportion of DALYs representing 56.7%, followed by neurological disorders representing 28.6% and substance use disorders with 14.7% (Whiteford

et al., 2013; Whiteford et al., 2015). In low and middle-income countries (LMICs), the problem is compounded by the seeming lack of access to quality mental health services (Becker & Kleinman, 2013), and limited data on the distribution of mental disorders. Close to one-third of all countries report no actual data on the prevalence, incidence, remission, or excess mortality due to mental or substance use disorders (Vos et al., 2020). Other factors include poverty, competing priorities with infectious diseases, and inadequate health system resourcing to provide adequate services to people with mental illness.

Despite this increasing global burden of mental disorders, low resourced countries are ill-equipped to address mental health needs due to lack of mental health policies and more importantly the many major practical barriers to policy implementation (Freeman & Funk, 2007). The WHO advocates for community-based mental healthcare instead of institutional care (World Health Organisation, 2014). The acknowledgement that mental disorders are a global challenge with a huge burden, especially in developing nations, has provoked policy development in many countries, with a preference for community-based care as the best option for providing mental health services instead of institutionalisation (Hazelton, 2005). Whereas the new policy directions have not gone unopposed, they have also not attracted the needed and desirable support for increasing citizen participation and greater human rights protections for people living with mental disorders (Morrall & Hazelton, 2004).

Given the vulnerabilities and social instability associated with mental illness, it is important to protect the universal human rights of citizens (Turner, 1993), hence the inclusion of people living with mental disorders under the 1948 United Nations Universal Declaration of Human Rights. The UN further outlined some of the rights to include access to the best available medical treatment, to be diagnosed without any political meddling, and to be protected from exploitation, discrimination, and stigma (Kanter, 2006).

1.4 International context of mental health care

Mental healthcare is undoubtedly a global concern (Kessler et al., 2009; Patel et al., 2018; Prince et al., 2007). The UN Sustainable Development Goals (SDG) call for all nations to ensure healthy lives and promote well-being for all by 2030 (Holden et al., 2017; Lee et al., 2016). The third goal of the SDGs adopted by all the world's governments in 2016 included commitments by members nations to improve mental health and prevent and treat substance use disorders (United Nations, 2018). The WHO (2012) has reported that people with mental health disorders globally continue to face human rights violations. Lack of access to primary mental healthcare resulting in congestion in the limited number of psychiatric facilities has been identified as a contributing factor to human rights violations (Akpalu et al., 2010; Freeman & Pathare, 2005). Notwithstanding this, there is increased recognition internationally of the

state's responsibility to protect its citizens' human rights, including those who live with mental illness (Kleinman, 2009). Societal discrimination against people with mental disorders is not limited to the health sector but occurs across almost all spheres of life.

Freeman and Pathare (2005) have reported that people living with mental disorders are sometimes excluded from community life and denied fundamental human rights such as access to shelter, food and clothing. In all jurisdictions, people with mental health disorders continue to experience discrimination and denial of full citizenship rights. This is particularly evident in the areas of employment, education, right to vote, and in some cases, the right to marry (Drew et al., 2011). There is evidence to support a relationship between mental illness, denial of full citizenship rights and poverty (Flisher et al., 2007; Freeman & Pathare, 2005).

The UNCRPD to which many countries are signatories outlines universal guidelines and standards for treating and managing people living with mental disorders (Rasmussen & Lewis, 2007). This instrument aims to promote and protect the human rights of all persons with disabilities (Bartlett, 2012; Rasmussen & Lewis, 2007; United Nations, 2006). Nevertheless, most countries continue to struggle to meet the UNCRPD standards because of numerous competing challenges, including controversy concerning how this applies to people with mental disorders, especially the capacity to consent for treatment.

Mental health is recognised globally as a human rights concern and a major contributing factor to the global burden of disease (Drew et al., 2011) . There is, however, a disparity in terms of national funding for mental health. Whereas between 7% and 14% of national budgets are allocated to health, with a reasonable percentage of the amount going into mental healthcare in many developed countries, this amount is much lower, in the order of 1% to 5% in developing countries, and in some cases, mental health is virtually ignored (Jenkins, 2005).

There have been some initiatives with legislative backing to improve service delivery, but implementation remains a major challenge for most developing countries. Subsequently, there is a large treatment gap for people living with mental and neurological disorders (Kohn et al., 2004; Lund, 2015). With the increasing numbers of people living with mental disorders, interest in improving healthcare delivery for this vulnerable population has grown. However, the implementation of proven interventions, such as enacting mental health legislation remains inconsistent in low resourced countries (Lund et al., 2011).

Traditional and faith-based healing is widely used in many developing countries, perhaps to reduce the treatment gap (Gureje et al., 2015; Ojagbemi & Gureje, 2020). Practice by TFHs, traditional healing uses local herbs to treat diseases or health challenges, while faith healing concerns the use of religious prayers and fasting for the treatment of illness. In Africa, roughly 80% of the population use traditional herbs and prayers for healthcare (Abbo et al., 2019; Abd

El-Ghani, 2016; Elujoba et al., 2006; Ohemu et al., 2017; Ozioma & Chinwe, 2019; Raphael, 2011). Ghana, just like other African countries with similar demographic characteristics, seeking help from TFHs for mental ill-health is common and may be seen and interpreted as a stopgap approach for reducing the wide treatment gap for mental ill-health. There are reports of human rights violations of persons patronising traditional healers (Read, 2012; Ssengooba et al., 2012). Given the inadequate resourcing and lack of access to biomedical services concomitant with the prevalence of TFHs in low- and middle-income countries, it is inevitable that there will be debate concerning whether inter-sectoral partnerships between biomedical providers and TFHs might prove to be an effective strategy for overcoming treatment gaps for the seriously mentally ill (Ae-Ngibise et al., 2010; Patel, 2011). There is need for strategies and initiatives to improve the mental health knowledge of at least some of the spiritual healers to eliminate the use of restrictive and inhumane activities routinely in use at the prayer camps.

1.5 Mental health policies in African countries

There remains a paucity of evidence-based policies governing mental healthcare across Sub-Saharan Africa. In the few countries where policy and legislation have been developed, implementation has stalled due to failed political leadership and resourcing difficulties (Drew et al., 2013; Lund, Mental, et al., 2010). In Africa, 46% of countries that reported to the WHO's 2014 Mental Health Atlas survey did not have or had not implemented standalone mental health policies, compared with 24% of countries globally (Sankoh et al., 2018). This figure is an improvement from the 64% of countries in Africa that did not have mental health legislation or had legislation that was obsolete and failed to sufficiently uphold the rights of people living with mental disorders in 2004 (Freeman & Pathare, 2005; Gostin & Gable, 2004).

More than 40% of countries in Africa do not have community-based mental health services; as a result, mental health service provision is concentrated in major cities and provided through a minimal number of psychiatric hospitals (Akpalu et al., 2010; World Health Organisation, 2005). Although the 2005 WHO report recommended that member nations should take concrete steps in promoting and improving mental health, little progress has so far been made (Doku et al., 2008; Flisher et al., 2007). Mental healthcare is given little or no priority compared to other diseases in most African countries (Lund et al., 2016; Weinmann & Koesters, 2016).

1.5.1 Mental healthcare in Ghana

Ghana is a country with limited mental healthcare provision by international standards (Badu et al., 2018; Saxena, Thornicroft, et al., 2007). There is limited epidemiological data on the burden of mental illness in Ghana (Bird, Omar, Doku, Lund, Nsereko, Mwanza, et al., 2011; Roberts et al., 2014). The prevalence of mental illness is estimated at 13%, and most people

with mental illness are seen on an out-patient basis (Addo et al., 2013). With 30.8 million people (Ghana Statistical Service, 2021), inpatient psychiatric services are limited to three main State psychiatric hospitals (Akpalu et al., 2010). Mental health services are available in a limited number of facilities, mostly along the coastal towns in Ghana (Figure 2) prior to the introduction of the MHA. There are a lack of trained mental health professionals and formal services available to adequately cater for the mental health needs of the population (Adu-Gyamfi, 2017; Roberts et al., 2014).

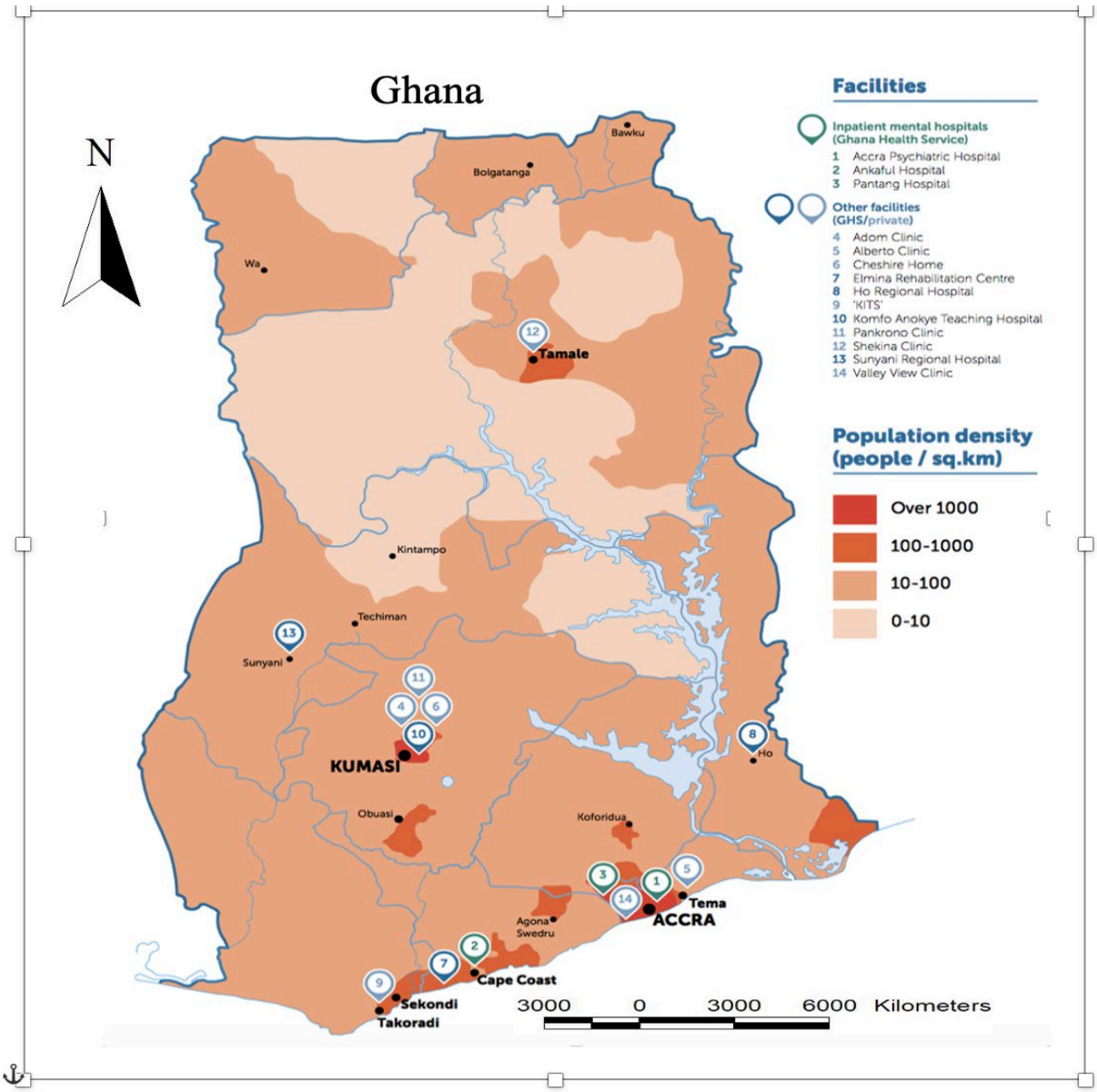

Figure 2: Map of Ghana showing population density and mental health facilities

A decade ago, studies assessing mental health services and legislation in Ghana documented insufficient numbers of trained mental health workers, neglected infrastructure, widespread stigma, insufficient funding and inequitable geographical distribution of services (Ofori-Atta, Read, et al., 2010; Roberts et al., 2014). Not much has changed.

In Ghana, help-seeking for mental health is influenced by the individual's belief system and aetiology attribution. People with mental disorders will seek treatment at TFH centres if they believe the cause of their condition is spiritually interconnected (Ae-Ngibise et al., 2010; Anyinam, 1989; Osafo, 2016).Therefore, psychiatrists, TFHs provide mental health services; however, there is little or no coordination between these different service providers (Ofori-Atta et al., 2018). This highlights the need for collaboration between mainstream healthcare delivery and traditional and faith-based practitioners to address the treatment gap (Ae-Ngibise et al., 2010; Asamoah et al., 2014; Ofori-Atta et al., 2018; Patel, 2011). Approximately 70% of the Ghanaian population live in rural areas with limited access to biomedical health services (Tabi et al., 2006) which tend to be on the coast. In the early 2000s, studies reported that the ratio of medical doctors to the population in Ghana is 1: 20,000 and the ratio of TFH to the population is 1: 200 (Ae-Ngibise et al., 2010; Hill et al., 2014; Krah et al., 2018). TFHs provide an accessible form of healthcare in Ghana, and for the most part, are the first point of call especially for people living with mental disorders (Ae-Ngibise et al., 2010; Tabi et al., 2006). Ghana passed the Traditional Medicine Practice Act 595 in February 2000 to promote, control and regulate traditional and alternative medicine practices through formulation, implementation, co-ordination, monitoring and evaluation of policies and programs. Although the Traditional Medicine Practice Council was established in 2010 and regulatory structures instituted, there continues to be irregular monitoring and supervision of TFHs. Various human rights violations continue to occur, such as physical beatings and restraining patients through the use of chains, and forcing patients to go without food for several days or weeks, in the belief that such measures will weaken evil spirits, especially in prayer camps (Ssengooba et al., 2012). In some spiritual healing homes, also called prayer camps, individuals were often chained to trees without shelter from the harsh tropical climate, and forced to fast for weeks as part of a ‘healing process’, while being denied access to medications (Ssengooba et al., 2012). Prayer camps are widely accepted because of their proximity to service users and also the belief in spirituality within the cultural context. However, there are reported concerns about human rights violations such as chaining and flogging which service users are sometimes subjected to as part of the healing process.

Given the lack of orthodox mental health services throughout Ghana, it is common practice for people with mental health problems to seek treatment from both TFHs and biomedical healthcare (Ae-Ngibise et al., 2010; Osafo, 2016; Read et al., 2009). TFHs may be consulted

before and/or after seeking psychiatric treatment (Read, 2012). Human Rights Watch, an international non-government human rights organisation, reported numerous human rights abuses of persons living with mental disorders across the country (Ssengooba et al., 2012). The report described how many people with mental disorders were forced to live in traditional and faith-based treatment camps, often against their will and without the capacity to challenge their confinement (Ssengooba et al., 2012). According to the report, patients in psychiatric hospitals faced overcrowding and unsanitary conditions.

People with mental disorders face considerable community stigma and discrimination and frequently lack shelter, food, clothing, and healthcare. Inter-sectoral collaborations between mainstream community mental health services and traditional or prayer camps are considered possible, but such partnerships should be based on agreed governance and ethical standards (Ae-Ngibise et al., 2010; Ofori-Atta et al., 2018). The standards and governance requirements for these collaborations are yet to be established (Arias et al., 2016). Lack of progress in this area is related to traditional and faith-based leaders' failure to recognise the need to modify their practice (Read et al., 2009), and lack of trust between the disparate stakeholder groups of TFHs and biomedical mental health service providers (Ofori-Atta et al., 2018).

To some extent, the current state of services can be viewed in terms of post-colonial developments (Asare, 2010; Kpobi et al., 2013; Walker & Osei, 2017). Since independence from Britain in 1957, with the growing population, efforts to redirect services from exclusively focusing on a small, privileged section of the population to the whole population in the face of severe resource limitations has become a significant public policy challenge (Aikins & Koram, 2017; Doku et al., 2012).

Among the various progressive social policy aspirations that leaders within Ghana have had since decolonisation, one has been to improve health, and more recently, this has been expanded to include mental health. Therefore, the MHA was developed in line with emerging international best practice and implemented from 2012 onwards. However, there have been significant implementation challenges.

1.5.2 Mental health legislation in Ghana

The earliest mental health legislation in Ghana was the 1888 Lunatic Asylum Act of the then Gold Coast. The Colonial Government enacted this legislation purposely for the confinement of people with mental disorders from the public. The Lunatic Asylum Act was subsequently replaced by a Mental Health Decree (NRCD 30) in 1972 by the Military Government of the National Redemption Council (Mental Health Decree NRCD 30, 1972). Unfortunately, the policies and programs emanating from the Acts were never implemented (Adu-Gyamfi, 2017; Doku et al., 2012).

The gap between enacting laws and implementation represents another layer of impediment for people with mental disabilities, no matter how those laws have been crafted (Callard, 2012; Lockwood et al., 2014). With the transition from intermittent military rule to democratic Government since 1992, there have been efforts to reform mental health, culminating in the enactment of the Mental Health Act (MHA) 846 in 2012. The MHA makes provision for the protection of the rights of people living with mental disorders. The MHA defines mental disorders as a condition of the mind in which there is a clinically significant disturbance of mental or behaviour functioning associated with distress or interference of daily life and manifesting as disturbance of speech, perception, mood, thought, volition, orientation or other cognitive functions to such a degree as to be considered pathological but excludes social deviance without personal dysfunction. The main aim of the MHA is to provide legislative direction to a new system of mental healthcare in Ghana. It provides a legislative platform for developing a contemporary, community-based mental healthcare system to ensure the provision of quality of mental health services and protection of the rights of persons with mental disorders (Walker & Osei, 2017).

The existence of national mental health strategies is important to guide the integration of mental healthcare into primary care. This approach has been reported to be effective in improving the responsiveness of the health system to the needs of people with mental health problems and disorders in other African countries such as Ethiopia. Hanlon, et al., (2017) in reviewing mental health reform in Ethiopia noted a parallel process and model to that being applied in Ghana (Hanlon et al., 2017). Whilst the MHA was introduced in 2012, the LI that allows for operationalising the MHA remains stalled in the labyrinth of Government process. The LI is the statutory tool (Doku et al., 2012; Walker, 2015) required to release the necessary resources for the implementation of the MHA and associated reform procedures.

The MHA was passed by Parliament after eight years of development and broader consultation with key stakeholders locally and internationally. The Mental Health Department of WHO gave financial and technical assistance during the formulation and revision of the legislation (Doku et al., 2012; Walker & Osei, 2017). The unimplemented Mental Health Decree of 1972 (Osei et al., 2011) was therefore replaced by the MHA, which has been hailed by international bodies, including the WHO, as an example of best practice in mental health legislation and could potentially serve as a model for other developing countries (Walker & Osei, 2017). The main sections of the MHA are as follows:

- Rights of persons with a mental disorder;
- Protection of vulnerable groups;

- Procedures for voluntary and involuntary admission and treatment;
- Creation of the Ghana Mental Health Authority (GMHA);
- Establishment of Mental Health Review Tribunals;
- Establishment of Regional Visiting Committees;
- Establishment of a Mental Health Fund;
- Introduction of sanctions for the offences of neglect of or discrimination against persons with a mental disorder.

The MHA contains a number of enforceable protective rights and standards concerning least restrictive alternatives for treatment, protection of confidentiality, access to information and the equal right of all citizens to employment (MHA 846, 2012).

1.6 The legislative process in Ghana

The process of enacting laws in Ghana involves the crystallisation of many ideas from different people and institutions. Several different key agencies and individuals play major roles in the lawmaking process in Ghana. Private citizens, public officers, Non-Governmental Organisations (NGOs), Government departments (including the Law Reform Commission, Attorney General's Office, Ministries) and many others could initiate and influence legislation. Nevertheless, the power to construct and pass laws in Ghana is shared between parliament (which passes the bill to an Act) and the President (who assents the bill into law) (1992 Constitution of the Republic of Ghana). It is important to note, that Article 93 of the Ghana Health Service and Teaching Hospitals Act 525 of the 1992 Constitution clearly states: "The legislative power of Ghana shall be vested in Parliament and exercised in accordance with this Constitution" (Ghana Health Service and Teaching Hospitals Act 525, 1996).

1.6.1 Implementation of the MHA to date

The implementation of the MHA has faced many challenges with little progress being made since its commencement (Adu-Gyamfi, 2017). Institutions directly or indirectly responsible for the implementation of the MHA need to understand their roles and responsibilities. Some challenges including a shortfall of mental health workers, inadequate mental health information systems, insufficient funding, social service provision and access to legal services were anticipated by Doku et al. (2012) at the time the MHA was passed into law in 2012 (Doku et al., 2012). Since the MHA came into existence almost a decade ago, the following achievements can be noted:

- Establishment of the GMHA to supervise the delivery of mental healthcare in the country;
- Appointment of a board of directors of the GMHA for oversight responsibility;
- Appointment of Regional Mental Health Coordinators (RMHC) for the organisation of mental healthcare at the subregional level;
- Drafting of the LI (LI2385) for the MHA (Walker & Osei, 2017), which has recently been passed by the Parliament of Ghana into law in 2020.

A number of major impediments to the implementation of the MHA have also been identified (Adu-Gyamfi, 2017; Walker & Osei, 2017):

- Undue delay in passing the LI by Parliament to ensure statutory resource allocation for the implementation of the MHA;
- Limited dissemination and public awareness of the MHA;
- Lack of access to people with mental disorders in non-orthodox mental health facilities;
- Insufficient mental and allied health workers;
- Inadequate facilities for mental healthcare delivery including rehabilitation centres.

1.7 The Ghana Mental Health Authority (GMHA)

1.7.1 Establishment

The passing of the MHA, established a statutory body known as the GMHA, with primary responsibility to oversee the implementation of the MHA and to provide high level oversight of mental healthcare delivery throughout the country. At the time of its establishment, the GMHA received strong endorsement from political, professional and community leaders in Ghana (Doku et al., 2012; Walker & Osei, 2017). The major statutory responsibilities of the GMHA are to:

- Develop mental health policy and oversee the MHA implementation;
- Consult with service users and providers to provide humane care within the least restrictive environment;
- Promote culturally appropriate and safe mental healthcare and integrate service delivery with general health and primary care systems and private providers at the district, regional and national levels;
- Develop resources and structures that allow for voluntary as well as involuntary care;

- Promote the human rights of persons with mental disorders and protection against discrimination and stigmatisation;
- Promote affordable, accessible and equitably distributed specialised mental healthcare

1.7.2 Organisational structure

A further structural barrier is the exclusion of the GMHA from the governing body, that is, the Ghana Health Service which has overall responsibility for delivering healthcare across the country. Historically, Ghana's Mental Health Service had operated a parallel system with the Ghana Health Service (GHS) and this has been maintained into the current period (Ghana Health Service and Teaching Hospitals Act 525, 1996). Under the MHA, as noted by Doku et al. (2012), there is no direct structural representation of the Mental Health Department within the MoH and therefore no links with the Directorate of Public Health in the Ghana Health Service (Doku et al., 2012) . This organisational structure of the GMHA, which has the mandate to oversee the implementation of the MHA, is thus likely to be problematic. This is because the current mental health legislation although promising, must be put into effect with very limited resources and needs to use the established structures such as the GHS to maximise resources.

Although the GMHA is directly under the MoH, a closer alignment with the GHS may likely result in accessible mental health services. There is a high level of stigmatisation of mental illness in Ghana, integrating mental healthcare into the main healthcare system would likely improve cohesion between these services. This could contribute to more effective care and the better use of resources, while at the same time reducing the mental health-related stigma that is so evident in African countries such as Ghana. Such initiatives would likely support the restructuring of the GMHA to be fully integrated into the GHS for more effective service provision. A development such as this would be consistent with the call by the WHO to integrate mental health services within the general health sector globally (World Health Organisation, 2008).

1.8 Role of critical stakeholder collaboration in mental healthcare

A number of significant stakeholders contribute to the provision of mental healthcare in Ghana. The ones discussed in this section include NGOs, National Council of Persons with Disability, and Community Opinion leaders. Since the introduction of the MHA, Ghana has come under greater scrutiny from international actors responsible for monitoring the progress of policy promulgation and implementation, health standards, human rights and progress towards universal health coverage including the WHO, Human Rights Watch, World Bank and the UN.

State and private institutions are directly or indirectly responsible for, or involved in, the implementation of the MHA. It is possible that some of these institutions are either not meeting their mandated responsibilities, or are oblivious to their role regarding care for people with mental disorders. For instance, the District Assemblies are the local Government administration in charge of implementing central Government policies which includes the MHA. The District Health Services are responsible for implementation of health policies. The Department of Social Welfare and Community Development is duty bound to provide support for people with disabilities which includes people with mental illness (Local Governance Act 936, 2016). The Commission for Human Rights and Administrative Justice is responsible for the protection of human rights which includes persons with disabilities. As a result of the restricted promotion of the MHA, some of these organisations may not be aware of their roles and/or the provisions set down in the MHA. Awenva and others have reported more than a decade ago that there is usually inadequate stakeholder collaboration and wider consultation during the development of policies which makes their implementation very difficult (Awenva et al., 2010). These authors subsequently recommended wider consultation with key stakeholders and a review of policies to facilitate their implementation. It is imperative that these potential inherent barriers are explored in order to identify policy gaps in implementation in the districts; and to create awareness and adopt strategies for multi-sectoral collaboration for the implementation of the MHA at the district level and for scale up nationwide.

Also critical to the implementation of the MHA is the role of NGOs and Community Opinion Leaders. These stakeholders play a major role in mental healthcare in Ghana and are thus significant players in the reform agenda. NGOs are supporting mental healthcare through various advocacy programs. As not-for-profit organisations, NGOs including Basic Needs Ghana and MindFreedom Ghana, are partnering with the GHS and the GMHA, to increase the possibility that people with mental illness are able to access mental health treatment. There has been some training by these NGOs regarding the MHA.

It should be noted that the importance of Community Opinion leaders as gatekeepers, cannot be underestimated, especially in relation to the implementation of new policies and programs at the community level. In the context of Ghana, such stakeholders would include Chiefs, Queen Mothers, Assembly Members, and Family Caregivers, who are seen to be custodians of the laws and norms of the community (Asante et al., 2013). Chieftaincy could be described as the traditional indigenous institution of governance and leadership in Ghana and other African countries (Marfo, 2019). Research has shown that traditional or community leaders are held in high esteem as figureheads and “parents”; they are the interface between Government and the people (Honyenuga & Wutoh, 2019). Also, they represent the symbol of unity in times of conflict or disagreement and can settle disputes between individuals, families, clans and

communities, and protect their subjects and initiate development projects (Honyenuga & Wutoh, 2019; Stoeltje, 2019). The 1992 Constitution guarantees the institution of Chieftaincy and its traditional structures as established by customary law; the establishment of a Ministry responsible for Chieftaincy in Ghana demonstrates the vital role of Chiefs in the socio-economic development in Ghana (Asamoah, 2012). It is not surprising that some developing countries have made deliberate efforts at decentralising their public service in line with this ancient approach (Sakyi et al., 2011). For instance, in South Africa, the Local Government Law makes provision for the representation and participation of Chiefs at the Municipal Council (Mathenjwa & Makama, 2016). Although the legal framework for the Metropolitan, Municipal and District Assemblies (MMDAs) in Ghana Act 462 excludes the representation of traditional authorities in the governance structure of the MMDAs, these authorities remain important community stakeholders and gatekeepers of the communities (Asante et al., 2013).

1.9 Prayer camps and the role of TFHs

Indigenous healing practices in Ghana were devalued during colonisation to the degree that the British introduced the Native Customs Regulation Ordinance of 1878, which made it illegal for Indigenous healers to practice. Independence from Britain in the late 1950s heralded a new opportunity for further promotion of traditional healing to be recognised as an adjunct to orthodox treatment, especially for illnesses where there was no recognised biomedical treatment.

Although Ghana is a secular state, Christianity is the largest religion with over 70% of the population being a member of various Christian denominations (Ghana Statistical Service, 2021). A number of churches own and operate prayer camps where people access spiritual healing. One such Christian organisation is the Pentecostal Church, which has a long-standing tradition of assisting followers to manage their psychosocial and sometimes economic problems (Arias et al., 2016; Asamoah et al., 2014). People go to the prayer camps to seek help for various forms of sickness, including mental illness. TFHs including prayer camps are integral to the provision of mental healthcare in Ghana (Ae-Ngibise et al., 2010; Ofori-Atta et al., 2018; Peprah et al., 2018). The evangelical Christian denominations are primarily responsible for the administration of prayer camps in Ghana.

The Ghana Federation of Traditional Medicine Practitioners Association was formed to unify the various disparate Indigenous practitioners. Further to this, the Ministry of Health released a National Strategic Plan for Traditional Medicine Development in 1999, which was further facilitated by the Traditional Medicines Practice Act (Act 575) in 2000, to promote, control, and regulate the practice of traditional medicine in Ghana.

The main emphasis under Act 575 focussed on the Indigenous healers including diviners and herbalists to the neglect of the practices of Christian and Muslim faith healers. The majority of Christian faith healers are Pentecostal or charismatic and therefore healing is considered an integral part of their religious expression. Whilst their churches are required to be registered with the Ghana Pentecostal and Charismatic Council, their healing centres known formally as prayer camps are not registered as healthcare facilities with Government as their practices also include prayers for non-health problems. The majority of prayer camps offering spiritual healing for mental health problems are unregulated (Read et al., 2009). The precise number of camps in Ghana is currently unknown, although it is estimated that there could be several hundred (Edwards, 2014; Read et al., 2009). Unfortunately, non -regulation of prayer camps has resulted in gross violation of human rights for many residents who have sought care for their mental health issues. In 2012, Human Rights Watch reported human rights abuses in a number of these unregulated prayer camps (Ssengooba et al., 2012). The centrality of these unregulated prayer camps to the community remains a challenge to implementing the MHA.

Critical stakeholders in mental healthcare have postulated the need for formal collaboration between mainstream healthcare delivery and TFHs to create dualism of care, and a strategy to offset the existing mental health treatment gap (Ae-Ngibise et al., 2010; Asamoah et al., 2014; Ofori-Atta et al., 2018; Patel, 2011). The development of practices and guidelines by the GMHA to regulate TFHs provides a long-term policy intervention to embed a dualistic system in which both conventional healthcare practitioners and TFHs are formally sanctioned components of the Ghana mental healthcare system. An essential statute of the MHA protects the human rights of mental health sufferers and regulates the provision of mental healthcare throughout Ghana. The current MHA provides for oversight supervision and monitoring of TFHs through visiting committees. Inter-sectoral collaborations between mainstream community mental health services and traditional practitioners or prayer camps are possible, but for such partnerships to succeed, they will need to be based on prescribed governance and ethical standards (Ae-Ngibise et al., 2010; Ofori-Atta et al., 2018). According to a number of studies, lack of collaborative progress is due to the failure of TFHs to recognise the need to modify their practices that violate human rights (Read et al., 2009b), and lack of trust between the disparate groups (Akol et al., 2018; Ofori-Atta et al., 2018).

A provision in the MHA, permits persons with mental health problems to contest their involuntary detention in formal psychiatric facilities. However, this is not the case for mental health patients seeking healing in traditional and faith-based healing camps. Affected persons or their families usually do not have the capacity to engage, or access legal support to request release from these camps. Further to this, TFHs carry referent power within their communities. Some people may not be aware of the provision that allows a person to self-discharge from

any health facility if they are not satisfied with the healthcare provided. Custom and practice has implied that only the religious leader of the prayer camp can determine when to unchain a patient with mental illness or release them back to the community.

While African pluralistic medicine is practised, the significance of traditional and faith-based healing to the Ghanaian population will require a new role for TFHs within a blended mental health service model. Such an initiative would also require that the mental health knowledge gap of the TFHs be addressed as part of a strategy for eliminating restrictive and inhumane activities. The realisation of improved mental healthcare and human rights protection under the MHA will require stronger key stakeholder collaboration and governance of activities within the traditional and faith-based healing camps.

Under the MHA, the GMHA has the overall legislative responsibility for governance of practice including the practice of TFHs. The MHA recognises the primary role of TFHs within the community. The GMHA has formally developed guidelines to govern and regulate the activities of TFHs in mental healthcare (Ghana Mental Health Authority, 2018). Critical areas in the guidelines include:

- All TFHs are required to be registered with the Traditional Medicine Practitioners Council, and their details are to be maintained on a central register under the auspices of the GMHA;
- Separate accommodation is to be provided, with basic utilities including potable water, hygienic toilets and bathing facilities;
- Provision of clothing and adequate diet remains the responsibility of the camp and the patient/relative;
- Safety and welfare of patients under the care of the camp is paramount;
- Training of TFHs in relevant aspects of mental healthcare be developed and provided by the MHA;
- The camps' leadership are required to respect and maintain the rights and dignity of patients under their care;
- Camps are required to maintain confidential patient records.

The guidelines are to ensure that those providing care and those receiving treatment do so in an acceptable way that does not infringe on the dignity and rights of the individual.

Considering the importance of TFHs to the successful implementation of the MHA and future models of mental healthcare across Ghana, an observational study was conducted in two prayer camps. The observational study aimed to examine administrative structures, patterns

of behaviour and treatment regimens within the camps, investigate the extent of any human rights abuses and to identify the degree of collaboration between prayer camps and other treatment providers including formal mental health services in Ghana.

1.10 Social protection programs

In Ghana, one of the social protection programs introduced by the Government of Ghana in 2003 is the National Health Insurance Scheme (National Health Insurance Act, 2003). The National Health Insurance Scheme was established as a safety net to ensure that all Ghanaians have access to basic health services. Whilst persons with mental disorders are registered free of charge, the scheme provides minimal coverage for accessing mental healthcare (Agyepong & Adjei, 2008). Under the current MHA, the provision of social support services is under the purview of the Ministry of Social Welfare and Community Development.

Another social initiative introduced by the Government of Ghana is the Livelihood Empowerment Against Poverty (LEAP) Program. The LEAP Program is a social protection initiative which provides cash transfer and health insurance to households living in extreme poverty and also for people with disabilities. Launched in 2008, with funding from the Government of Ghana, LEAP aims to alleviate short-term poverty and encourage long-term human capital development, and thus provides financial support for people living with mental illness as provided in the MHA. The program was supported by development partners including the World Bank and the Department for International Development (DFID) with technical support from UNICEF's social protection unit (Handa et al., 2013). The Department of Social Welfare and Community Development have the statutory responsibility to provide rehabilitative support to allow patients to integrate into the community. Considering the low numbers of professionally trained allied health clinicians, it is likely that the department currently lacks the human resources to support this mandated responsibility. Both anecdotal evidence as well as research conducted in this area have indicated that the LEAP program has primarily provided for the aged and physically disabled to the detriment of people with psychosocial problems and disabilities (Ae-Ngibise, Doku, et al., 2015) This could be considered as a structural form of discrimination, a transgression of the fundamental rights of people living with mental disorders.

1.11 Significance of the study

To date, mental health reform in Ghana has been limited, and little research has been conducted within the African sub-region to identify barriers impeding the implementation of mental health policies (Awenva et al., 2010; Badu et al., 2018; Doku et al., 2012; Faydi et al., 2011; Walker & Osei, 2017). Nonetheless, Ghana has an advantage over some African

countries because of the recent passage of the MHA. However, the introduction of the MHA is not a guarantee of sufficient and adequate mental health service provision for people living with mental disorders in the country. A number of mental health experts have described the MHA as a law designed to promote the creation of a modern community-based mental health system and for the protection of human rights of persons with mental disorders (Doku et al., 2012; Walker, 2015; Walker & Osei, 2017). It is expected that decentralisation of mental healthcare at the community level will decongest and reduce the bottleneck at the three main State psychiatric hospitals for better mental healthcare delivery (Akpalu et al., 2010). It is anticipated that these strategic changes will provide further protection for those living with a mental health disability.

The primary purpose of this Thesis are to: (i) assess the extent to which the provisions of the MHA are being implemented across Ghana; (ii) to document the barriers and enablers to implementation; and (iii) offer strategic recommendations to enhance further progress. The Thesis also assesses the feasibility of integrating TFHs into the formal system of care for people living with mental disorders and whether this could be accomplished without infringing on patients' rights, as has occurred in the past. Key stakeholders' knowledge and preparedness for implementing the MHA are assessed, and the findings and recommendations made available to the GMHA through to the Ghana Health Service/ MoH. In a broader sense, it is likely that the findings of the study will have implications for other African nations struggling to upgrade their health and mental health legislation and services.

1.12 Justification for the research

Although the MHA received assent in May 2012, there has been no evidence-based evaluation of the progress of its implementation or impact at an end-user level. The research presented in this Thesis constitutes an evaluation of the mental health policy impact, including barriers and enablers to effective implementation. The Thesis explores how best to address the complex practice-interface between traditional and faith-based practitioners and mainstream mental health services within a regulated and statutory environment. Whilst African pluralistic medicine is practiced, the significance of traditional and faith-based healing to the Ghanaian population will require a new role for TFHs within a blended model of mental health care. The outcome of which may be transferrable to other African countries to fill the knowledge gap that exists in the continent. District level barriers to, and enablers of, implementation and central Government commitment to the course of mental health policy implementation are evaluated. This topic is of importance in resource-limited countries such as Ghana, where evidence-based health interventions consistently fail to reach those who need them, or are simply not implemented.

The research reported in this Thesis contributes information relevant for the implementation of the MHA at district, regional and national levels. The key focus of this Thesis is to investigate the barriers and enablers impeding the implementation of the MHA. This study has the potential to act as a blueprint for evaluating mental health policy within other developing Sub-Saharan African countries.

1.13 Research Question and Objectives

1.13.1 Research Question

The overarching research question for this Thesis is “What are the barriers and enablers for implementing the MHA throughout Ghana”?

1.13.2 Research Objectives

The research objectives and the data collection techniques are presented in Table 1.

Table 1 Thesis objectives, research questions and data collection methods

Research objectives	**Research questions**	**Type of study and method**
1. To measure demographics and degree of disability among people with severe mental illness in the Kintampo North Municipality of Ghana	1. What is the degree of disability among people with severe mental disorders in the Kintampo North Municipality of Ghana?	Study 1 (Chapter 4): Quantitative survey
2. To assess the role of TFHs in mental healthcare and document human rights abuse at prayer camps and their preparedness for collaboration with orthodox health services	2. What is the role of TFHs in implementing the MHA in Ghana?	Study 2 (Chapter 5): Observation at prayer camps
3. To assess the barriers and enablers for implementing the MHA	3a. What is the role of key stakeholders/institutions in implementing the MHA in Ghana? 3b. What is the progress, barriers, and enablers for implementing the MHA in Ghana?	Study 3 (Chapters 6 – 10): Qualitative survey using Indepth Interviews (IDIs) and Focus Group Discussions (FGDs)

These Thesis objectives were met via quantitative and qualitative methods, including: (i) study 1 - a quantitative survey among people living with severe mental disorders to describe disability, support and knowledge of the MHA; (ii) study 2 - an observational study at two prayer camps to assess human rights abuses; and (iii) study 3 - IDIs/FGDs to characterise the barriers and enablers for implementing the MHA.

1.14 Structure of the Thesis

The Thesis is organised into eleven chapters under 3 studies. The first three outline the context for the work, while the last eight present the findings of the research.

- Chapter 1 introduces the burden of mental disorders globally and in Ghana in particular. The introduction of mental health legislation pre-and-post colonialism and the progress

of implementation of the MHA have also been described. The objective of the Thesis is presented in this chapter

- Chapter 2 presents the theoretical framework for the study. The theoretical framework was informed by a narrative literature review. The barriers and enablers to implementing mental health policies as well as the role of TFHs are described.
- Chapter 3 provides a description of the study methods, and research design including data collection and analysis. The theoretical considerations underpinning the research and ethical considerations and regulatory approvals for the study are also presented.
- Chapter 4 reports on the knowledge and awareness of the MHA from the perspective of people living with severe mental disorders. The chapter further reports on the impact of the MHA on service delivery and how mental illness interferes with daily functional abilities of service users. Chapter 4 is reported under study one.
- Chapter 5 was conducted under study 2 and reports the findings of an observational study that explored the human rights concerns of service users who seek spiritual healing at prayer camps.
- Chapters 6 – 10 are presented under study 3, qualitative data using IDIs and FGDs. Chapter 6 reports on the progress of implementation of the MHA since its introduction in 2012 and discusses the need for relevant stakeholders to prioritise and advocate for investment in mental healthcare.
- Chapter 7 outlines and discusses the barriers affecting implementation of the MHA as discussed by mental health sector stakeholders in Ghana.
- Chapter 8 considers the role of TFHs in mental healthcare and the need for governance and regulation to prevent human rights abuse in treatment centres. Also, mental health service users' and carers experiences of using TFHs as a treatment option for mental illness is described.
- Chapter 9 explores stakeholders' perspective on enablers for implementing the MHA and discusses the strategies that would further facilitate the speedy implementation of the MHA to promote quality mental healthcare service delivery in Ghana.
- Chapter 10 discusses the role of key stakeholders in facilitating the implementation of the MHA to improve mental health delivery.
- Chapter 11 discusses the findings of the Thesis, focussing on identified key barriers and enablers for implementing the mental health reform in Ghana. The role of TFHs situated in the context of human rights abuse at healing centres is also discussed in

this chapter. Conclusion and recommendations to support implementation of the MHA and conclusions are also presented.

1.15 Chapter summary

Chapter 1 presented a brief description of the burden of mental disorders globally and in Ghana in particular. The chapter focused on the international context of mental healthcare with particular attention to mental health legislation in Ghana. The history of mental healthcare in Ghana and the significance and objectives of this Thesis in investigating the barriers and enablers for implementing the MHA in Ghana have been described. Chapter 2 presents the theoretical framework of the Thesis.

Chapter 2 Theoretical Framework

2.1 Overview

In this chapter, a narrative literature review technique (Creswell, 2013) is used to assess previous work pertinent to the barriers and enablers to implementing mental health laws in developing countries. The purpose of this Thesis is to investigate barriers affecting mental health service provision in Ghana and attempts to address the challenges by implementing a modern MHA and developing upgraded services from 2012 onwards. A narrative or traditional literature review is a comprehensive, critical and objective analysis of the current knowledge on a topic of interest. Using narrative review was essential because it helps in establishing a theoretical framework and context for the research (Ferrari, 2015; Green et al., 2006). A particular focus is on the MHA. A summary of previous work done in this area is presented. This chapter also further presents literature on the role, relevance and practices of TFHs in mental healthcare. In addition, a conceptual framework underpinning the current study, highlighting the knowledge gaps is discussed.

2.2 Search methods

Search terms used for the narrative literature review are presented in Table 2. In the narrative literature search, the influential WHO Seven Health System Building Blocks (HSBB) framework was used as a guide for the review. Although there is a growing body of literature on mental health reform in low-income countries, literature on mental health research in Ghana is limited. The Ghanaian literature is made up of papers from local and foreign researchers and expats, some in senior overseas positions who have maintained an active interest in the mental health system in Ghana.

Table 2 Search Terms and databases used for the narrative literature review

Key Search Terms	**Alterative Search Terms**
Mental Health Act:	mental health act; Government policy making, legislative processes; healthcare policy, public policy combined with; mental health/illness/etc. Human rights and disability
Barriers and Enablers:	Barrier*, Enable*, (impede* or impediment*) Facilitate*, Challenge*, (hindrance* or hinder*), Obstacle*, Hurdle*, Opportunit*, Adher*, Inhibit
Traditional and faith-based healing	traditional medicine, Africa indigenous medicine, prayer heal*, herbal treatment, faith healing
Implementation	Implement*, Dissemin*, Adopt*, Transform*, Translat*, Uptake*, Incorporate*, Integrat*, Scale up, Adher*
Scope	Low and middle income countr*, Africa, Ghana

The database used for the literature search included Medline, Embase, CINAHL, PsycINFO, African Index Medicus, Scopus, Anthropology and African Religion. Grey literature was searched in addition to the electronic databases. The search was conducted on title, abstract and keywords. References of the retrieved articles were also manually assessed for other potential studies that reported on the topic area. The articles identified were exported to Endnote and the duplicates were removed. Full-text articles were then reviewed thoroughly, examining patterns and developing subtopics. The purpose was to analyse the current knowledge critically and objectively to establish a theoretical framework and focus of the Thesis. Thousand three hundred and eighty-one articles were retrieved from the initial search and 318 articles were reviewed and included based on the search criteria. The articles included qualitative and quantitative studies that reported mental health policy implementation challenges in low- and middle-income countries, focusing on the 2012 Ghana Mental Health Act.

2.3 Barriers to mental health policy implementation

As identified by Doku et al. (2012) and Walker (2015), there are potential barriers to the implementation of the MHA (Doku et al., 2012; Walker, 2015). These barriers include organisational structure, human resources, social services, judicial, the role of the Commission for Human Rights and Administrative Justice (CHRAJ), limited publicity of the MHA, lack of political will for the passage of the LI, role of TFHs and mental health information systems. Other identified challenges include media reporting about mental health, poor mental health literacy of the community and belief systems (Ae-Ngibise et al., 2010; Barke et al., 2011; Ofori-Atta, Read, et al., 2010). These initially identified system and individual barriers were corroborated by Awenva et al. and Ofori-Atta et al. in 2010 when they provided a situational analysis of mental health in Ghana and potential challenges moving on from policy development to implementation (Awenva et al., 2010; Ofori-Atta, Read, et al., 2010).

Similarly, Hanlon et al. (Hanlon et al., 2017) identified barriers impeding the development of mental healthcare in Ethiopia which are comparable to those reported in Ghana. In their qualitative study, Hanlon et al. reported challenges such as low awareness about mental healthcare planning, widespread stigmatising attitudes, a lack of transparency in planning decisions and limited leadership for mental health. Other factors included lack of co-ordination of mental health planning, erratic supplies of medication, inadequate health management information system indicators for monitoring implementation, lack of community mobilisation for mental health and low involvement of stakeholders in local mental healthcare planning. Studies in other sub-Saharan African countries including South Africa, Uganda and Zambia have also reported similar barriers to mental health policy implementation (Faydi et al., 2011; Lund, Mental, et al., 2010).

Previous research has reported deficits in the global delivery of mental health services (Razzouk et al., 2010). Even in regions where mental health services are generally available, a proportion of the population with mental illness do not receive the necessary healthcare specific to their illness (Becker & Kleinman, 2013; Hanlon et al., 2017). Hanlon et al. (2017) subsequently recommended the need for strong mental health leadership co-ordination throughout Ethiopia, the expansion of indicators for routine monitoring of mental healthcare, promotion of service user involvement and addressing widespread stigma and low mental health awareness. These challenges and possible facilitating factors are presented in a conceptual framework in Figure 3.

The WHO is heavily involved in national and international improvement of mental health policy and has developed a framework to guide mental health policy development globally. These guidelines and frameworks assist in developing health policies in all countries, whether they

are low, middle, or high-income countries. The next section outlines a theoretical framework that underpins the research reported in this Thesis.

2.4 Theoretical Considerations

Research has trialled different approaches for researching health policy implementation. One well-documented approach represented in the literature is implementation research. Implementation research, or science, has been described as a relationship between policy and action, involving negotiations and interactions in social and political contexts using social science research methods to understand what and how things happen (Barrett & Fudge, 1981; Hamilton & Finley, 2019; Theobald et al., 2018). Health policy on the other hand commonly refers to the formal written documents, rules, and guidelines that present policymakers' decisions about what actions are deemed legitimate and necessary to strengthen the health system and improve health (Sheikh et al., 2011).

It is important to understand what the key considerations are in the conduct of health policy research. The literature reviewed suggests that there are important themes to consider when reviewing policy analysis and implementation (Bach-Mortensen et al., 2018; Kitson et al., 2013). Some of these themes include funding, workforce, governance and healthcare delivery. While there were differences between some of the articles that were reviewed for this purpose, this Thesis has been informed by the WHO HSBB (World Health Organisation, 2007) and the Learning Health Policy System (LHPS) (Oh et al., 2021). The theoretical considerations in this Thesis align with the WHO HSBB framework (Figure 3 and Figure 4) and the LHPS (Figure 5).

2.4.1 The WHO Seven HSBB

The seven HSBB include service delivery, health workforce, health information system, medicines and technologies, health financing, leadership and governance and people. Previous studies have indicated that the WHO HSBB framework is instrumental in strengthening the overall health system and a catalyst for achieving global health targets such as the SDGs (Manyazewal, 2017; Sacks et al., 2019).

In this Thesis, public policy refers to implementing the statutory requirements of the MHA and concomitant mental health reforms. The barriers cited in the literature including relevant stakeholder collaboration, legal, resources, health system organisation, political and socio-cultural, social welfare support, inadequate information systems, limited exposure and role of significant partners are imbedded in the WHO HSBB framework (Doku et al., 2012; Osei, 2019; Walker & Osei, 2017). This framework provides a guide for evaluating the fidelity and effectiveness of the implementation of the MHA to date.

A criticism of the WHO HSBB framework has been that the building blocks alone do not constitute a system, any more than a pile of bricks which can be constructed as a building without interactions (De Savigny & Adam, 2009). Positioning people and their institutions in the centre of this framework reinforces WHO’s renewed commitment to the principles and

values of primary healthcare: fairness, social justice, participation and inter-sectoral collaboration (World Health Organisation, 2007, 2008). Therefore, placing the community at the centre creates an interconnectedness between people and systems. This is particularly critical in implementing the MHA because people and their institutions are expected to play significant roles. Key stakeholders, including individuals, civil society organisations, service users and carers, health professionals, community opinion leaders, traditional leaders, health managers and policymakers all have critical roles to perform to advance the implementation of the MHA. The dynamic architecture and interconnectedness of the WHO HSBB are illustrated in Figure 4.

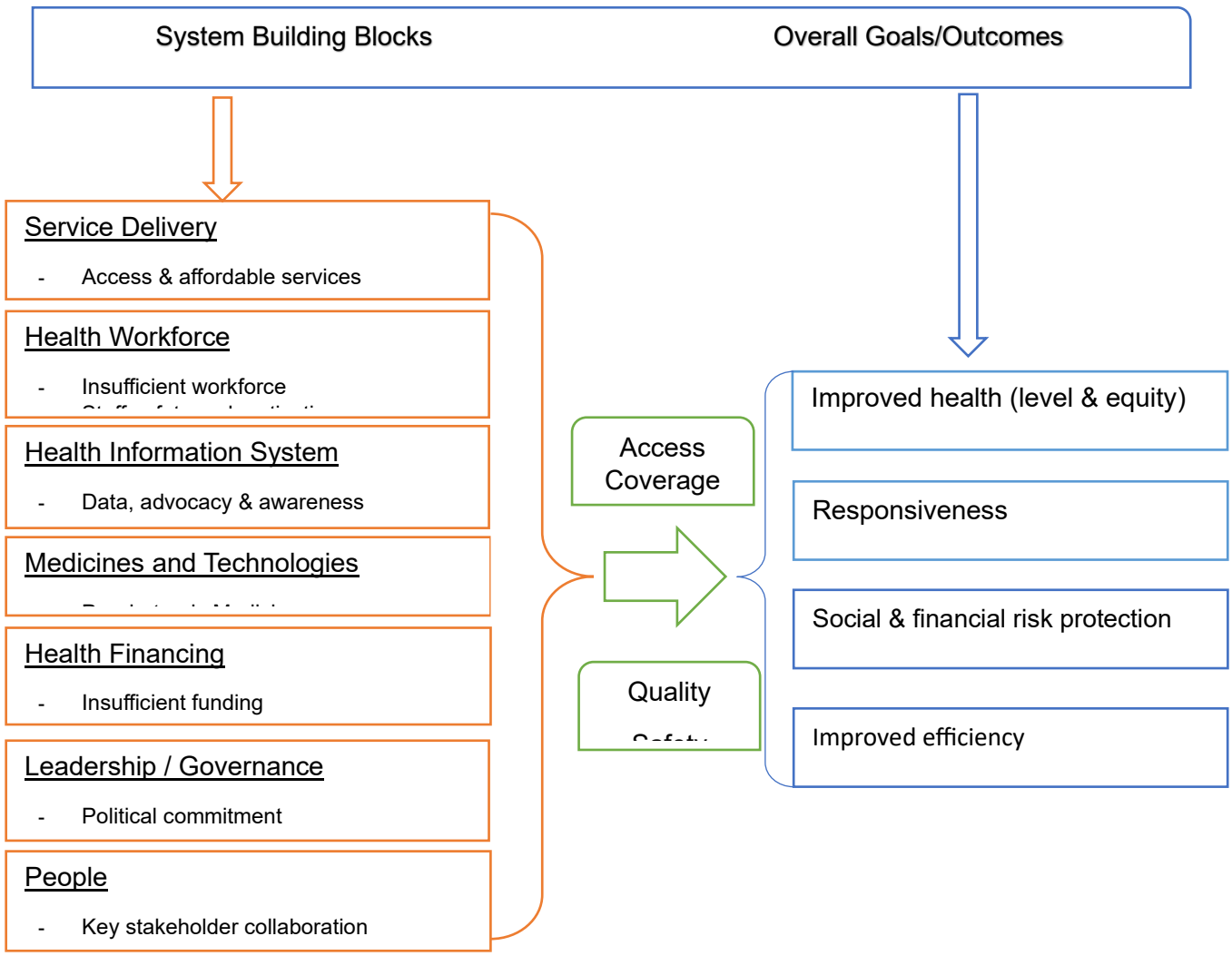

Figure 3: The WHO Health System Building Blocks (HSBB) Framework (WHO, 2007)

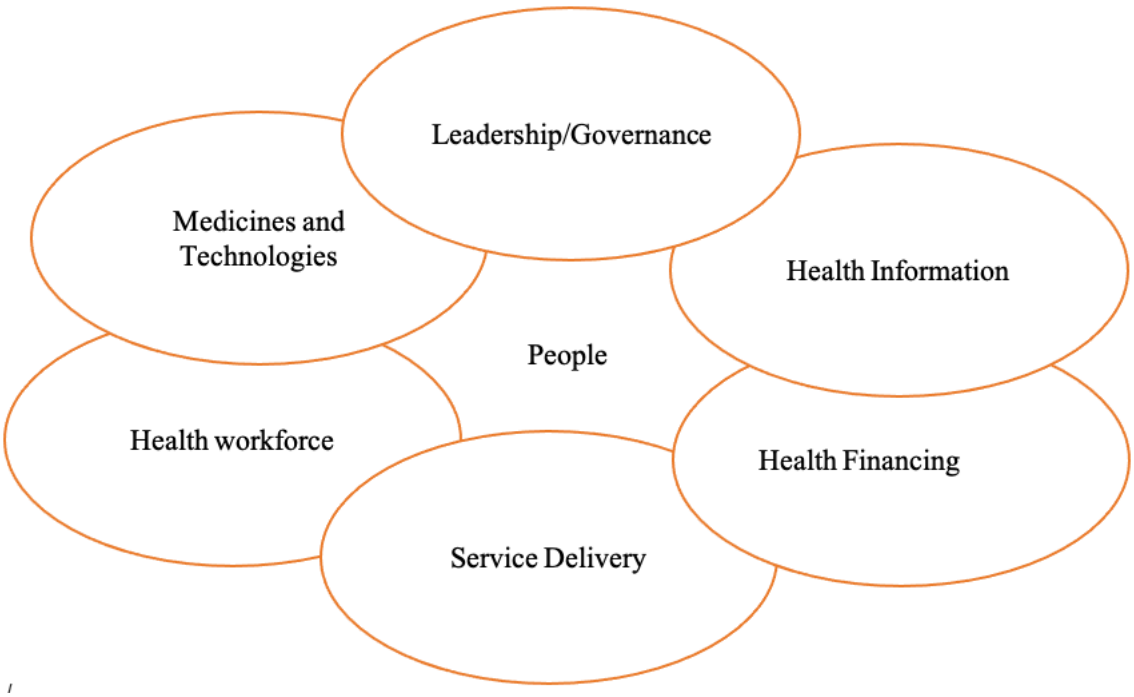

Figure 4: The dynamic architecture and interconnectedness of the WHO HSBB (Systems thinking for health systems strengthening, WHO, 2009)

2.4.2 The Learning Health Policy System

The Learning Health Policy System (LHPS) is a further policy implementation framework utilised within this Thesis. LHPS is a strategy that describes a continuous policy implementation evaluation, allowing for an interdisciplinary and comprehensive examination of how health systems respond and adapt to health policies, and how these policies shape health systems and the broader social and structural determinants of health (Oh et al., 2021).

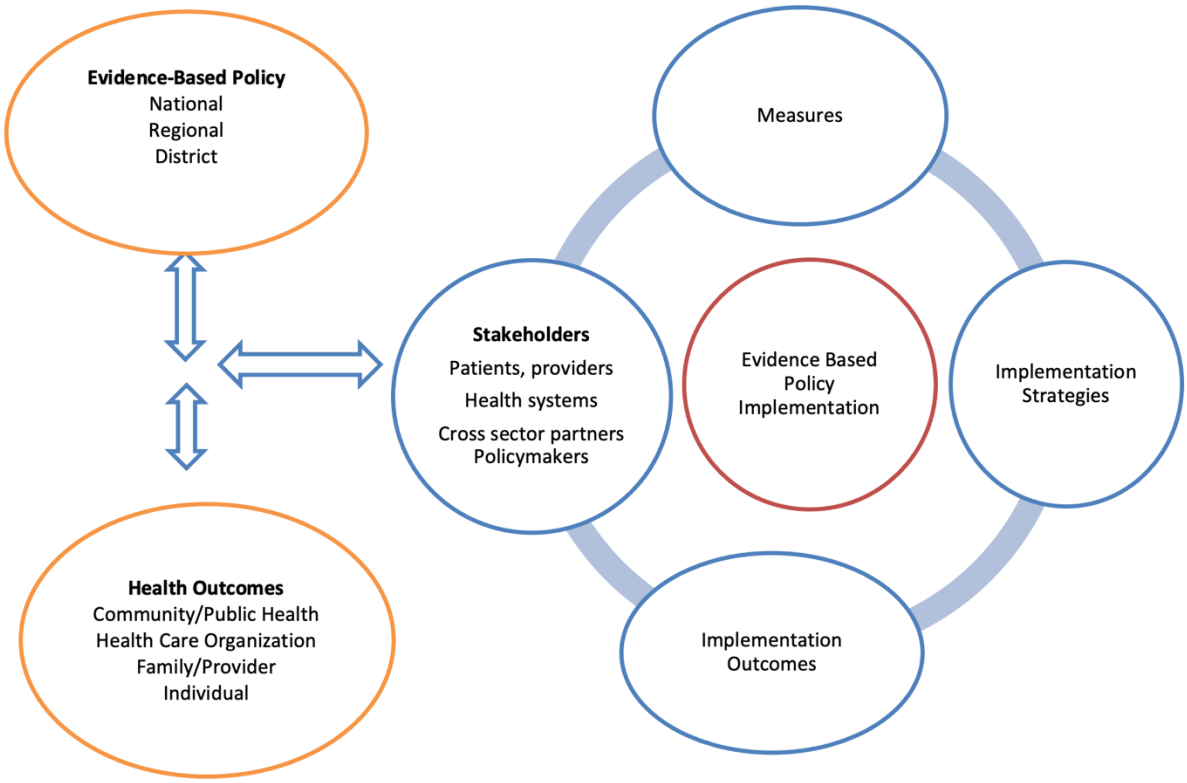

Figure 5: Learning health policy system

2.5 The WHO Health System Building Blocks (HSBB)

The WHO provides a global context through policy initiatives to improve mental healthcare in all countries. The seven WHO HSBB provide a useful theoretical framework for researching the process and outcomes of policy implementation in the mental health field. The WHO HSBB framework has guided the design, construction and conduct of the Thesis. Applying the WHO HSBB to the Ghana mental healthcare context suggests important considerations which are discussed in sections 2.5.1 - 2.5.7. For the purposes of this Thesis, the WHO HSBB framework

will be discussed in the following order: people, health financing, health workforce, medications and technologies, information, leadership and governance, and service delivery.

2.5.1 People: Mental health literacy, help-seeking and human rights

'People' are listed as a key HSBB by the WHO. In this context the term refers to the community in general but more specifically to consumers, carers, health providers and funders including various levels of Government. Relevant stakeholders play a central role in the implementation of the MHA. To date, there has been no research to estimate the level of community knowledge of consumers' or carers' understanding of their rights, entitlements, and responsibilities under the MHA. Likewise, there is no data addressing service providers' knowledge of their statutory obligations under the MHA. This is a potential impediment to the successful implementation of the MHA. This presents as a possible obstruction to good governance as service users are not necessarily aware of their rights while providers are not being held accountable. This lack of knowledge is reported to potentially increase human rights violations (Mfoafo-M'Carthy & Huls, 2014).

The published literature to date suggests that the general population's knowledge of the MHA is limited, and thus cannot demand accessible and quality mental healthcare. This lack of knowledge on the part of the populace means that people may not be able to make demands on Government through the GMHA to ensure that mental health is given a similar level of attention as other healthcare areas. Lack of mental health awareness as a potential factor that impedes effective mental healthcare implementation has been reported in Ethiopia (Hanlon et al., 2017) and other low-income countries (Eaton et al., 2011). In a report by Hanlon et al. (2014), community mental health literacy was reported to be low in five low- and middle-income countries and there were no formal collaborations between biomedical practitioners and traditional or religious healers (Hanlon et al., 2014).

The culture and behaviour of people are also key factors that need to be addressed if the MHA is to be successfully implemented. The extent to which people understand mental illness affects their help-seeking behaviour and acceptance of the mental health reform agenda. Some people believe strongly that mental illness is caused by spiritual forces and needs a spiritual solution to mitigate its impact (Ae-Ngibise et al., 2010). This would appear to be heavily based on ethno-cultural identity and belief systems and has little to do with the availability and costs of treatment (Campbell-Hall et al., 2010; Kpobi & Swartz, 2019; Ofori-Atta et al., 2018). Limited mental health literacy, as understood in the western biomedical context, and subsequent reliance on traditional healing systems is prevalent across the African continent (Berry & Crowe, 2009; Campbell-Hall et al., 2010; Ngulube, 2017) and also among Africans residing in the diaspora and other parts of the world (Harley, 2006). As a result, the

prevalence of stigma experienced by people and families living with mental disorders influences help-seeking preferences (Ae-Ngibise, Doku, et al., 2015). One of the main differences between African pluralism and western biomedicine centres around disease aetiology. This juxtaposition between traditional, animistic and spiritual belief systems and conventional psychiatry presents a critical tension point and a potential barrier to reforming mental healthcare in Ghana (Ngulube, 2017).

Human rights considerations also underpin this research. Human rights have been enshrined in the UN Declaration of Human Rights (1948) and the Convention on the Rights of Persons with Disabilities (UNCRPD, 2006), which came into force in 2008. Given the vulnerabilities and social variability associated with people living with mental illness, the 1948 UN Declaration of Human Rights included people living with mental illness as a means to protect their rights (United Nations, 1948). The United Nations further outlined some of the rights to include access to the best available medical treatment, to be diagnosed without any political interference, and to be protected from exploitation, discrimination, and stigma (Kanter, 2006). Coercion in psychiatry and broader mental health services is a global concern that needs to be addressed (Puras & Gooding, 2019). The UNCRPD has provided a roadmap for all member nations and key stakeholders to reorganise and address long-standing power imbalances and implement innovative policies to improve on the rights of people with disabilities including mental health (Mfoafo-M'Carthy & Huls, 2014; Patel et al., 2012; Puras & Gooding, 2019).

The need to protect human rights is universal, yet people with mental illness have historically been subjected to abuses of human rights in all aspects of their lives including some substandard conditions in mental health facilities and community settings (Patel et al., 2012; Patel et al., 2018). Patel and Bhui (2018) argued that a rights-based approach must enforce established international human rights conventions, and scale-up community mental health services instead of using chains, incarceration and abuse in prisons or psychiatric hospitals which is an affront to psychiatry and humanity (Patel et al., 2018). In Ghana, the Persons with Disability Act, 715 (PWD Act 715, 2006), passed in 2006 established the National Council of Persons with Disability to oversee the implementation of the Act. The Act provides the legal framework for the promotion and protection of the rights of Persons with Disability (PWDs). As a human rights and advocacy group, the National Council of Persons with Disability is expected to play a very important role in the implementation of the MHA.

In response to increasing violations of the rights of people living with mental illness across the globe, the WHO has developed the QualityRights project to train all key stakeholders about the rights of people living with mental disabilities (World Health Organisation, 2012). Key stakeholders targeted for this training include mental health service users and their families to demand their rights; health and mental health professionals to understand the rights of patients

and apply these in practice; and the police force, lawyers, magistrates and judges who make important decisions concerning the rights of people living with mental disorders (World Health Organisation, 2012). Other interventions such us service user-led advocacy and the development of community mental healthcare could play a significant role in addressing some of the abuses against people with mental illness.

Increasing mental health literacy is being acknowledged as an important strategy to promote early identification of mental illness, reduce stigma and enhance help-seeking behaviours for people living with mental illness (Arthur et al., 2020; Wei et al., 2015). Poor mental health literacy has been reported to increase the likelihood of human rights violations because of uncertainty regarding seeking appropriate support for mental health due to stigmatising attitudes towards people living with mental disorders (Arthur, 2018; Mfoafo-M'Carthy & Huls, 2014). Previous studies around the world have suggested the need to initiate programs to improve mental health literacy in order to prevent mental disorders (Gorczynski et al., 2017; Tully et al., 2019) and to empower service users to understand and make effective use of medical information including adherence to treatments (Kutcher et al., 2016). The need to build a broad and critical understanding of all individuals' rights, especially people with mental illness as a vulnerable group, is important. Hence, these initiatives by international organisations underscore the need to implement the MHA to improve mental health services and to protect the rights of people living with mental illness (Patel et al., 2018).The Mental Health Leadership and Advocacy Program (mhLAP) was instituted in English speaking countries, including Gambia, Ghana, Liberia, Nigeria, and Sierra Leone, to enhance the acquisition of skills in mental health leadership, service development, advocacy and policy planning and has the potential to strengthen leadership and promote consistent advocacy for change (Abdulmalik et al., 2014).

2.5.2 Health financing

Highly influential international organisations such as the WHO have asserted that adequate funding is essential for building a more effective healthcare system. The WHO describes health financing as raising adequate funds for health in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them. Adequate health financing ensures sufficient allocation of resources that improves quality, equity, and efficiency. There is generally a large shortfall of resources for mental healthcare delivery in Ghana due to insufficient mental health funding. Researchers have reported on the low budgetary allocation for mental healthcare by the central Government, and the insufficient physical infrastructure for the delivery of mental healthcare (Ofori-Atta, Read, et al., 2010; Roberts et al., 2014).

Awenva et al argued that the current health funding model in Ghana is inadequate and unsustainable due to its heavy reliance on donor funding (Awenva et al., 2010; Raja et al., 2010; Roberts et al., 2014). External investment masks the persistent inequity of internal funding in mental healthcare. A qualitative study by Awenva and colleagues concluded that external reliance and insufficient internal funding acted as a barrier to mental health policy translation into practice (Awenva et al., 2010). Awenva et al. (2010) further argued that the personal level of discrimination and institutionalised stigma was further replicated through the structural, institutional level of Government acting as a further barrier to mental health investment and reform. Therefore, the funding allocation for mental healthcare in Ghana has been affected negatively by stigma that questions the rationale for investing funds into caring for people living with mental disorders deemed incapable of contributing to national development (Awenva et al., 2010). This negative view by segments of Ghanaian society has significant implications for the provision of financial support for mental healthcare because of a perceived lack of importance and negative societal attitudes towards mental healthcare in Ghana. This also points to the centrality of anti-stigma or discrimination strategies in any approach to implementing mental health reform in Ghana.

Doku et al., (2012) argued that successful implementation of the MHA will require substantial financial investment from Government and stakeholder engagement (Doku et al., 2012). Roberts et al. (2014) identified that the mental health share of overall health spending was 1.4% in 2011. Despite the huge burden of disease and disability associated with mental disorders in Africa and other low income countries, several authors stated that the majority of sub-Saharan African countries spend less than 1% of their already small health budgets on mental healthcare (Alloh et al., 2018; Daar et al., 2014; Petersen et al., 2017). The effect of such a low level of funding is further compounded due to a lack of transparency of distribution (Roberts et al., 2014). Besides, the GMHA has no control over the allocated budget (Roberts et al., 2014), since these budgets are allocated from central Government. Whilst other levels of Government, including Municipal or District Assemblies and the Social Welfare Department are required to supplement mental health funding, the process lacks clarity and accountability. For instance, under current arrangements the Department of Social Welfare is responsible for rehabilitation and reintegration of people with mental health problems discharged from mental health facilities into the communities (Mental Health Act 846, 2012). Among other duties, the District Assemblies are responsible for ensuring that the basic needs of people with mental illness are provided. (Local Governance Act 936, 2016). The preparedness and capacity (through the allocation of supporting funds) of these major stakeholder groups to meet their obligations under the MHA still hangs in the balance due to the inability to approve the mental

health LI. The GMHA will inevitably have to be allocated an agreed recurrent budget to meet its statutory obligations as prescribed by the MHA.

Akpalu and colleagues have highlighted the inadequate distribution of mental health funding across Ghana with the major investment being concentrated on the major metropolitan centres of Accra and Cape Coast, both located in Southern Ghana (Akpalu et al., 2010). The MHA and associated policy reforms have been predicated on a decentralised and accessible model for all communities in Ghana. This geographical imbalance in resourcing between Northern and Southern Ghana will remain a barrier to progress without redistribution or further capital investment (Ofori-Atta, Read, et al., 2010). This was recognised as far back as 2007 by Saraceno and colleagues who argued for transitional funding to support a seamless move into a decentralised community-based model of care (Saraceno et al., 2007). However, their research did not investigate primary stakeholders' views on how best to go about this transition for maximum impact. Availability of resources through adequate funding is critical for implementing the MHA.

2.5.3 Health workforce

The WHO indicates that a well-performing health workforce needs to be supported by a skilled workforce with adequate policies and legislations backing the process. A well trained and qualified workforce is important for healthcare delivery. The success of any organisation, including healthcare services, depends on the availability and professionalism of its workforce. Therefore, for the MHA to be fully implemented, there must be adequate and well-trained mental health workers to provide the services envisaged in the reform agenda. These professionals include psychiatrists, psychologists, mental health nurses, social and occupational workers, and other allied health workers. A number of studies have highlighted the lack of professionally trained mental health clinicians as a major barrier to the implementation of mental health reforms (Ae-Ngibise et al., 2010; Akpalu et al., 2010; Awenva et al., 2010; Doku et al., 2012).

Data from the 2014 Mental Health Atlas indicated that there were only 2,890 mental health staff (World Health Organisation, 2014) and a small number of other health workers available to service the mental health needs of 30.8 million Ghanaians (Ghana Statistical Service, 2021). In 2014, the estimated mental health workforce per 100,000 population comprised 0.06 psychiatrists, 0.03 psychologists, 0.05 social workers, 7.34 mental health nurses, 2.69 other mental health workers and 0.04 other medical doctors (World Health Organisation, 2014).

An earlier study conducted by Roberts and colleagues that assessed the Ghana mental healthcare system using the standard WHO Assessment Instrument for Mental Health System (WHO-AIMS) tool reported lower numbers of mental health staff (Roberts et al., 2014),

compared with the global average of 9.0 per 100,000 (Sankoh et al., 2018). Overall, the African region reported 1.4 mental health workers per 100,000 people, compared with a global average of 9·0 per 100,000 (Sankoh et al., 2018). Interestingly, the debate regarding the apparent shortfall in staff working in mental health has always centred on conventional professionals such as psychiatrists and mental health nurses to the neglect of other allied health professionals who play a significant role in modern mental healthcare delivery worldwide. A multi-professional approach to implementing the MHA would be advantageous in addressing the shortfall in the mental health workforce and ongoing service delivery (Roberts et al., 2014).

Doku and colleagues identified the need to expand the training of mental health professionals to include training in specialist mental health areas such as forensic, child and adolescent, learning disability and addiction psychiatry so that the MHA can be implemented comprehensively and holistically (Doku et al., 2012). Some of these specialities, such as forensic mental healthcare, are currently not available in Ghana. A study by Agyapong and colleagues identified what was described as workforce expansion through task-shifting, whereby responsibilities are distributed to lower level mental health workers or primary care health workers as another option to improve the human resource base for mental healthcare (Agyapong, McAuliffe, et al., 2016). Several authors described a tension with this proposal due to a perceived lack of training to adequately manage complex clinical cases without sufficient supervision from professional mental health workers. Others argued that with the absence of professional mental health workers and the limited mental health services in Ghana (Agyapong, McAuliffe, et al., 2016; Read, 2012), task-shifting may be the best approach, at least initially to bolster the insufficient health workforce to improve general healthcare delivery (Okyere et al., 2017). However, Agyapong and colleagues argued that this option may not be feasible because general healthcare providers are already over-stretched (Agyapong et al., 2015). A study assessing the acceptability and feasibility of task-shifting and task-sharing as potential solutions for mental healthcare in low and middle-income countries has reported that the approach is not a complete solution for workforce shortages without consideration of remuneration, training and supervision through an increased investment in the sector (Padmanathan & De Silva, 2013). Notwithstanding this, increasing the numbers of professionally trained mental health workers will be required for Ghana to reach international standards of mental healthcare. There is a need for the GMHA and the Ghana MoH to develop ways of training a multi-disciplinary mental health workforce, which is currently lacking, to assist in implementing the MHA.

2.5.4 Medicines and technologies

The WHO HSBB Framework identifies the need for equitable and reliable access to first generation antipsychotic medications. Review of the literature identifies issues with access and consistency of supply of psychotropic medicines through public mental health services. For instance, procurement and supply of psychotropic medicines is inconsistent and affects the treatment regimens for people with mental disorders in Ghana and other low resourced countries (Antwi-Bekoe et al., 2009; Badu et al., 2018; Nyame et al., 2021).

Previous studies have reported the irregular supply of psychotropic medicines to meet the needs of people living with mental illness, leading to service users usually procuring medicine from private pharmacies (Awenva et al., 2010; Canavan et al., 2016; Ofori-Atta, Read, et al., 2010; Oppong et al., 2016; Raja et al., 2010; Roberts et al., 2014). Essential medicines such as antipsychotics, anxiolytics, antidepressants and mood stabilisers are frequently unavailable at health facility pharmacies leading to patients purchasing the medication from private pharmacists at their own expense, often beyond their financial capacity, which contributes to non-adherence and readmission (Badu et al., 2018; Ofori-Atta, Read, et al., 2010).

Lack of access to appropriate psychiatric treatment including medication is a major contributing factor to the global burden of mental illness. A consistent supply of psychotropic medications for people living with mental disorders is important but not within itself sufficient without adherence to treatment regime. This is because poor adherence to medications, including psychotropic medications, is a major contributor to the global burden of mental illness (Addo, Sencherey, et al., 2018; Mall et al., 2013; Zhou et al., 2019). It is thus important to work towards service users having an adequate understanding of the side effects and safety requirements for these medicines. Safety requirements in the context of this study also implies supporting TFH to better understand the side effects of psychotropic medications and to practice according to standard health service treatment guidelines (Green & Colucci, 2020). Limited Government funding and complex bureaucratic procurement processes have been cited as factors contributing to the shortage of psychotropic medications (Canavan et al., 2016).

2.5.5 Health information systems

The WHO HSBB framework acknowledges the importance of evidenced-based and culturally situated information for the effectiveness of health policy implementation. Dissemination of information for both the general public and key stakeholders is essential for implementing the MHA. Lack of reliable data on mental health systems in low- and middle-income countries (LMICs) greatly impedes workforce planning efforts. Approximately, one-quarter of LMICs have no system for reporting basic mental health information (Saxena et al., 2006; Upadhaya et al., 2016), affecting the ability of countries to assess the number of mental health professionals

needed to meet the population needs (Saraceno et al., 2007). There has been calls to strengthen mental health information systems through enhanced stakeholder consultations, careful consideration of implementation challenges during design, and a recognition of relations between different influences in order to monitor and evaluate mental health services in LMICs (Ahuja et al., 2016). Mental health information is needed for the development of mental health services globally and especially in LMICs because of the relative weakness of mental health systems in these countries (Lora & Sharan, 2015).

Adequate information will be required to assist key stakeholder understanding of the MHA, including their rights and responsibilities under the legislation. According to Doku and colleagues, there is a lack of adequate information about mental health in Ghana (Doku et al., 2012). In 2012, the GHS implemented an integrated and sustainable web-based District Health Information Management System (DHIMS-2) to improve on the information for healthcare delivery (Adaletey et al., 2014). The introduction of DHIMS2 has promoted data use for decision making, but there have been challenges with the system such as lack of funding, faulty equipment, and a lack of adequate skilled staff to ensure integrity of the data, all of which negatively impact on data quality (Adaletey et al., 2014).

As with other sub-Saharan African countries, Ghana does not have a national database on the burden of mental disorders to support strategic planning (Ahuja et al., 2016; Kpobi et al., 2018). The lack of mental health information systems is widespread in sub-Saharan Africa (Flisher et al., 2007). For example, a qualitative study in Ethiopia reported a lack of mental health data and information systems as a major impediment to service planning and clinical service development (Hanlon et al., 2017). This affects mental health policy implementation because of the lack of data for planning and decision making. Mutale and colleagues reported a lack of general health information for primary healthcare delivery and a need to improve health information systems for decision making across sub-Saharan African countries through the implementation strategies from the African Health Initiative (Mutale et al., 2013). Further to this, the lack of information for health planning is not limited to mental health but can also be found in general healthcare across the sub-Saharan Africa region (Odekunle et al., 2017).

2.5.6 Leadership and Governance

The WHO describes leadership and governance as a process that encompasses the systems by which an organisation is controlled and operates and mechanisms that regulate, create accountability and provide incentives within a strategic policy framework. According to a number of authors including Doku et al., (2012), Okrah (2014) and Walker & Osei (2017), the Government of Ghana has provided minimal leadership and governance to the implementation of the MHA since its inception. This is evident in the lack of commitment to put leadership

structures in place at the district, regional and national levels (Doku et al., 2012; Okrah, 2014; Walker & Osei, 2017).

As a medium-level developing country as defined by the UN Development Program (2016), Ghana's central Government faces many competing challenges and demands. As is often the case in developing countries, translation of mental health policy into practice is slow (UN Human Development Report, 2016). Regrettably, mental healthcare has not been a priority for different political administrations in Ghana in the past (Walker & Osei, 2017). Therefore, a top-down obligation by the State through the provision of resources for implementing the MHA is crucial for improving mental health service provision. This lack of political commitment and leadership could be interpreted as low priority being given to mental health, which is a major barrier for implementing the MHA in Ghana. Many other African countries have not paid attention to mental health resulting in the lack of specific mental health policies (Omar et al., 2010; Sankoh et al., 2018) and community-based mental health services (Akpalu et al., 2010; World Health Organisation, 2005). This is against the backdrop that most African countries including Ghana signed a declaration in 2014 to implement mental health policies that would address mental health issues confronting the continent (Daar et al., 2014).

Although resources are scarce, mental healthcare has not been given the necessary importance in Ghana's development agenda as evidenced by the limited mental health services over the years (Doku et al., 2012). This trend is similar across different African countries because there are reports of severe resource constraints for mental healthcare throughout the continent (Atilola, 2016). This resource limitation for mental healthcare is in direct contrast to growing international recognition that it is the State's responsibility to protect the human rights and citizenship entitlements of its citizens (Kleinman, 2009). According to Kleinman, failure to protect people living with mental illness is a failure of the State, and there is no ambiguity regarding the need for the State to demonstrate leadership by committing resources to reduce this human catastrophe. This raises questions regarding the role of the State in the provision of health and social care, including questions of how such provisions ought to be funded. It is also important to address issues surrounding possible sources of funding for mental healthcare. Within Ghana, such sources could involve partnerships between public and private sector stakeholders, with the latter including NGOs. Sources of funding external to Ghana could involve organisations such as the World Bank and the UK Foreign, Commonwealth and Development Office, which would involve the demonstration of good leadership and governance to achieve success.

It has been recognised locally and internationally that Ghana has shown some level of commitment to mental healthcare by enacting the MHA (Patel et al., 2018). However, the LI to provide the necessary framework including funding for implementing the MHA is pending

approval from the Parliament of Ghana. The lack of these legal powers and structures for implementing the MHA is a major concern for the GMHA, which has oversight responsibility for implementing the MHA. The apparent delay in passing the LI suggests the inertness of political leadership, affecting the full implementation of the MHA across the country.

Aside from the lack of activity of political leaders in driving the change for mental health reform, there is also a lack of clear institutional leadership and governance to ensure implementation of the MHA (Doku et al., 2012; Walker & Osei, 2017). For instance, the Commission for Human Rights and Administrative Justice (CHRAJ Act 456) is responsible for investigating complaints from persons whose rights have been violated or breached, but it is not explicit that the CHRAJ mandate on the Human Rights of people living with mental disorders (CHRAJ Act 456, 1993). These institutional challenges call for strengthening mental health system governance as a strategy to addressing these barriers which have been reported in six low- and middle-income countries in Africa and South Asia (Petersen et al., 2017). The MHA made provision for the establishment of Mental Health Tribunals to adjudicate over human rights abuses of persons with mental disabilities. It may be possible for the already independent CHRAJ to perform that responsibility for practical implementation purposes. Doku et al. (2012) have suggested that it may be prudent to delegate the functions of the Visiting Committees as set out in the MHA, to an independent body such as CHRAJ to oversee implementation (Doku et al., 2012).

2.5.7 Health service delivery

Service delivery has been described in the WHO HSBB to include effective, safe, and quality personal and non-personal health interventions provided to those in need, when and where needed (including infrastructure), with a minimal waste of resources (De Savigny & Adam, 2009). In other words, health system delivery comprises quality, appropriate access, safety and judicious use of resources. One of the major aims of the MHA is to improve access to quality mental healthcare. However, access to mental health services is limited due to the inequitable geographical distribution of these services (Ofori-Atta, Read, et al., 2010; Roberts et al., 2014). This limited provision of mental health services in Ghana has also been reported in other low- and middle-income countries including Ethiopia, India, Nepal and South Africa (Mendenhall et al., 2014; Skeen et al., 2010). Historically, mental health services have been provided by both orthodox and traditional and faith-based service providers (Ae-Ngibise et al., 2010), and this is also reported in other sub-Saharan African regions (Chidarikire et al., 2018, 2019; Ojagbemi & Gureje, 2020). A number of researchers have reported on the generally poor quality of mental healthcare throughout Ghana, linking this to the limited availability of mental health services (Akpalu et al., 2010).

There is broad recognition of the important role that TFHs play in mental healthcare, particularly in developing countries (Ae-Ngibise et al., 2010; Asamoah et al., 2014). TFHs are integral to the provision of mental healthcare in Ghana, and many Ghanaians have attended TFHs as their primary choice (Kpobi & Swartz, 2019). Across the African sub-region and other developing countries, TFHs are widely patronised for various reasons including cultural, accessibility and affordability (Esan et al., 2019; Green & Colucci, 2020; Gureje et al., 2015; Upadhyaya et al., 2018; Zuma et al., 2016). The WHO 2003–2020 Mental Health Action Plan called for Government health programs to include TFHs as part of the treatment package to help address the mental health treatment gap in low- and middle-income countries (Saxena et al., 2015). However, there is a growing body of literature questioning their efficacy, their role in relation to allopathic care, and ethical considerations (Gureje et al., 2015; Nortje et al., 2015; van der Watt et al., 2018). TFHs live in the same communities as people living with psychiatric disorders, and their services are therefore easily accessible and affordable for many people living with mental illness and this has been reported in a number of African and other developing countries (Burns & Tomita, 2015; Esan et al., 2019; Sessions et al., 2017). Also, the ratio of TFHs to the population contrasts dramatically with the ratio of bio medically trained health professionals to the population. Nevertheless, some patients still travel across regions or districts to access the services of TFHs.

Further to this, there have been an increased number of reports of human rights abuses especially at the TFH camps that have attracted global attention (Drew et al., 2011; Mfoafo-M'Carthy & Huls, 2014; Read et al., 2020), although such healers have also been established as playing an important role in different parts of the world (Green & Colucci, 2020; Gureje et al., 2015; Hindley et al., 2017; Younis et al., 2019). For instance, there is strong evidence of systematic abuse and gross human rights violations against people with mental illness in religious prayer camps which have been reported by the United Nations Human Rights Watch (Ssengooba et al., 2012). People with mental disorders have been physically beaten in order to exorcise a 'demonic spirit'; in some cases people have been chained to trees exposed to the weather; people have been compelled to fast for extended periods of time to weaken the 'bad spirits' in them or to atone for the sins they may have committed (Read et al., 2009). In addition to the physical abuse of patients, caregivers of people living with mental illness have sometimes been persuaded to fast in the prayers camps as well to help seek divine healing for their relatives. These unregulated community prayer camps remain a challenge to the implementation of the MHA. The belief in spirit possession and ancestral curse as contributing factors to mental illness is deeply ingrained within the Ghanaian psyche, hence the belief TFHs have the capacity to provide spiritual healing (Ae-Ngibise et al., 2010). However, the MHA now requires the GMHA to provide an oversight supervision through the visiting committees to

monitor the activities in these camps. TFHs, just like formal service providers should have the minimum ability to recognise someone suffering from mild to severe mental illness and be willing and able to refer cases that are beyond their capacity to formal service providers. It is also essential to ensure that service users, and TFHs, have sufficient understanding of medication side effects, safety requirements and standard health service treatment guidelines. Factors that impede the implementation of the provision of oversight supervision need to be investigated and addressed.

There is provision in the MHA to enable persons with mental disabilities to contest their detention in psychiatric facilities. However, this is not the case for mental health patients seeking healing in TFH camps. Affected persons or their families may not have the capacity or access to legal support to request release from these camps if they are mistreated or held against their will. Currently, treatment and discharge of camp residents is at the discretion of the non-clinically qualified religious leader. Whilst African pluralistic medicine is practiced, the significance of TFH to the Ghanaian population will require a new role for TFHs within a blended model of mental healthcare. Such an initiative would also require that the mental health knowledge gap of at least some of these spiritual healers be addressed as part of a strategy for eliminating the routine use of restrictive and inhumane practices in the camps. Provision of appropriate mental healthcare and protection of human rights under the MHA is achievable with stronger key stakeholder collaboration and oversight of the activities within TFH centres.

2.6 Knowledge gap

Notwithstanding the knowledge provided in the published literature, few studies have investigated approaches to closing the gap between policy development and implementation in the African context. This is the case in Ghana where little attention has focused on previous and current challenges of introducing statutory changes and mental health reforms. The challenge for most countries including Ghana is how to situate and reposition mental health as a priority for government funding amid other equally important developmental needs. As presented in section 1.4, there is a disproportion in terms of national funding for mental health across the African region. In developing countries, national budgets allocation for health generally is between 1% to 5%, and in some cases, mental health is not included in these allocations (Jenkins, 2005). In comparison, the developed countries allocate a reasonable proportion of national budgets for mental health. The annual average funding for health in the developed world ranges between 7% and 14%. The Thesis will drill down from the stakeholders' perspectives to identify factors influencing the lack of funding commitment for mental health and posit recommendations for addressing this lack of commitment.

To date, most research studies have used small sample sizes and were very limited in scope (Walker, 2015), or were largely speculation about anticipated barriers (Doku et al., 2012). Furthermore, previous research has mainly concentrated on the barriers, devoid of consideration of the possible enablers to change. This study will focus on both the barriers and potential enablers to implementation of the MHA.

The knowledge gap identified in the literature review has been the failure to address the complex interface between TFHs, and conventional psychiatry and how the former might usefully be integrated into mainstream mental healthcare for people living with mental disorders. The Thesis will identify acceptable ways and strategies from stakeholders for collaboration between TFHs and conventional mental health practitioners, to work together to improve mental healthcare. Likewise, these studies have not addressed the complex interface between formal Government statutory requirements and the role of traditional rulers in governance roles and the influence at the local community and district levels. In addition, so far there has been no formal assessment of the impact of the introduction of the MHA on the wellbeing and livelihood of people living with mental health problems and disorders.

There is a comparative Lack of research and other academic writing about mental health compared with other disease conditions in Africa. For instance, in April 2018, a search for “mental health disorders” in Africa via *The Lancet Global Health* produced 16 research articles, reflecting a dearth of mental health research in the African region (Sankoh et al., 2018). This compares disproportionately with 191 papers that were found for maternal health, 252 papers found for infectious diseases (HIV or AIDs), 165 papers for malaria, 114 papers for tuberculosis, 346 papers found for health systems, and 282 papers found for health policy. In other evidence, mental health was the subject of just 3% of clinical trials conducted in low and middle-income countries, with the majority of the research conducted in China (Sheriff et al., 2008). The lack of mental health research mirrors the weakness of mental health services on the African continent and the lack of priority attached to mental health by many Africans and their governments. As demonstrated in section 1.5, about 46% of African countries that reported to the WHO’s 2014 Mental Health Atlas survey either did not have or had not implemented separate mental health policies. This proportion compares with a global figure of 24% during the same period. With low workforce in the African region (1.4 mental health workers per 100000 people, compared with the global average of 9.0 per 100000), there are also fewer hospital beds for patients with mental disorders (Akpalu et al., 2010; Roberts et al., 2014; Sankoh et al., 2018). Despite the global annual rate of visits to mental health outpatient facilities being 1051 per 100000 population, the rate in Africa was 14 per 100000 (World Health Organisation, 2014). In Sierra Leone for instance, the mental health treatment gap has been

estimated to be 98.9% (Yoder et al., 2016). As a result, the proportion of Africans who have access to treatment for mental health conditions is extremely low.

As was reported by the WHO in 2018, despite the African continent population growing by 49% between 2000 and 2015, the number of years lost to disability because of mental and substance use disorders increased by 52%, corresponding to 17.9 million years lost due to those conditions. The impact of these mental health conditions is comparable to that for infectious and parasitic diseases that accounted for 18.5 million years lost to disability (World Health Organisation, 2018). Africa's population is projected to double over the next three decades (Nations, 2017). One implication of this population growth is that there will be intense pressure on young people in particular, already struggling across the African region to earn a living in highly competitive labour markets (Sankoh et al., 2018). Many people will experience psychological and mental health problems if they fail to realise their ambitions, and some will turn to substance misuse as a means of alleviating their frustration (British Council, 2018). Accordingly, the current Thesis will explore barriers to and enablers necessary for a timely implementation of the mental health policy to provide support for such people especially in the areas of prevention and treatment for mental health conditions.

The need for increased attention to mental health by governments, researchers, NGOs and other relevant key stakeholders is paramount. This Thesis addresses these gaps, investigates the barriers and enablers for implementation and considers strategies for progressing implementation of the MHA.

2.7 Chapter summary

Chapter 2 provided a narrative literature review to assess previous works that are relevant in documenting the barriers and enablers to implementing mental health laws in developing countries with particular reference to the MHA in Ghana. The role and relevance of TFHs in mental healthcare was also reviewed. Chapter 2 included a critique of the literature that is assessing the barriers and enablers of implementing mental health policies in Ghana. The theoretical framework underpinning the study was also presented. The framework referenced the WHO HSBB and the Learning Health Policy System. Chapter 3 presents the research methods used to conduct the research reported in the Thesis.

Chapter 3 Research Methods

3.1 Introduction

Chapter 3 presents the study design, methodology, and data sources employed in this Thesis. The purpose of the research reported in this Thesis is to assess barriers and enablers affecting mental health service provision in Ghana to address the challenges of implementing the MHA to improve service delivery. It is expected that the data gathered about the current state of mental health service provision will also be useful to the GMHA as this serves as baseline data for future measurement of the progress of implementing the mental health legislation. This chapter concludes with a discussion of ethical considerations and regulatory approvals obtained from the various institutional ethics committees required to conduct the research.

3.2 Research methodology and design

A mixed-method research design (Leech & Onwuegbuzie, 2009) involving qualitative and quantitative data collection methods and analysis were used in this Thesis. These methods were used to assess the barriers and progress of implementing the MHA from a range of stakeholder perspectives in Ghana. Tashakkori and Creswell (2007) have described the mixed-method approach as research in which the investigator collects and analyses data, integrates the findings and draws inferences using both qualitative and quantitative methods (Creswell, 2013; Tashakkori & Creswell, 2007). This methodological approach is commonly used in health service research where the subject matter requires examination from policy, resource, and end-user perspectives (Creswell & Poth, 2016).

The mixed-method approach was deemed appropriate as it was anticipated to unpack and provide a comprehensive understanding of the topic of interest by using complementary research approaches addressing the issues surrounding the MHA implementation. The method draws upon the strengths of using multiple approaches and at the same time, offsets the probable deficits inherent in single approaches employed for data collection. Therefore, it was expected that a mixed-method approach would support in-depth investigation of barriers and enablers to the implementation of the MHA, in a low resource service environment such as that found in Ghana.

This Thesis considers the pragmatic worldview, which hinges on the assumption that a phenomenon can be studied using emic (qualitative) and etic (quantitative) perspectives to

mitigate the weaknesses of adopting a single perspective. The emic view asserts that there is no absolute truth, because truth is discovered through an interpretation of a situation requiring a researcher to be deeply involved in the process to understand its complexities (Markee, 2013; Morris et al., 1999). This viewpoint is helpful in understanding experiences within and among groups. Conversely, the etic standpoint relies on objective means to study a phenomenon because of its belief that truth is absolute and does not require an interpretation (Morris et al., 1999; Olive, 2014). Emic and etic viewpoints were utilised to achieve the aims of this research.

The qualitative research component of the study draws on techniques from both ethnography and grounded theory for the data collection. Ethnography studies cultural groups in their natural setting over a period of time (Hamera et al., 2011; Reeves et al., 2008), while grounded theory is a form of inquiry from a sociological point of view using multiple stages of data collection that ultimately seek to provide explanation or theory behind events grounded in the views of research participants (Atkinson & Morriss, 2017; Charmaz & Belgrave, 2007; Chidarikire et al., 2019; Creswell & Poth, 2016). The qualitative aspect of the research presented in this Thesis, was designed to provide a deeper understanding of the study questions from the key stakeholders' perspectives concerning implementation of the mental health reforms introduced through the MHA. Qualitative data was collected from critical stakeholders including policymakers, mental health service providers, community opinion leaders, non-governmental organisations (NGOs), and TFHs.

Complementing this qualitative investigation, the quantitative component was used to collect data that describes the demographic, health and service use characteristics of people living with severe mental illness within the Kintampo area of Ghana. The purpose of collecting the quantitative data was to serve as a baseline for future evaluation of the impact of the MHA on mental healthcare in Ghana.

3.3 The study setting and population

The research was undertaken at the district, regional, and national levels within Ghana's health and mental health service sectors. As described in Chapter 1 (see section 1.2), Ghana is politically structured into 16 regions at the subnational level and then further divided into a series of administrative Metropolitan, Municipal and District Assemblies (these are the decentralised systems of governance at the local level). The statutory body, the GMHA, is responsible for implementing the MHA and the associated mental health reforms and a GMHA appointed coordinator is situated in each of these administrative regions. As the head of the regional mental health coordinating committees, these RMHCs are responsible for organising

mental health services as well as guiding and monitoring the required statutory changes within the mental health reforms. These informants were well placed to provide information on barriers and enablers for implementing the MHA within the context of their regions. The inclusion of the RMHCs in this study was expected to provide insights into how the issues identified in the Kintampo area are likely to be played out in other regions throughout Ghana. Collectively, the RMHCs provided a more national perspective on issues initially addressed within the regional context of the Kintampo area.

Data were obtained from each of these RMHCs, allowing for estimation of the progress of implementation at a national level. Demographics of the Kintampo North Municipality of the recently created Bono East Region represent a cross-section of the Ghanaian population (Owusu-Agyei et al., 2012). More detailed data was collected within the Kintampo North Municipality across a number of key stakeholders including health service providers, social welfare, the Commission for Human Rights, Police, Judiciary, and TFHs.

3.3.1 The Kintampo North Municipality and Kintampo South District

The Kintampo North Municipality and Kintampo South District is situated in the forest-savannah, transitional ecological zone in the middle belt of Ghana, and encompasses an area of 7,162 km^2 (Owusu-Agyei et al., 2012), with a total population of approximately 150,000 living in 161 communities. The setting consists of urban and rural communities with subsistence farming being the major occupation within the rural settlements (Owusu-Agyei et al., 2012). The location of the Kintampo area in the Bono East Region of Ghana which was created through a referendum in 2018 is shown in Figure 6.

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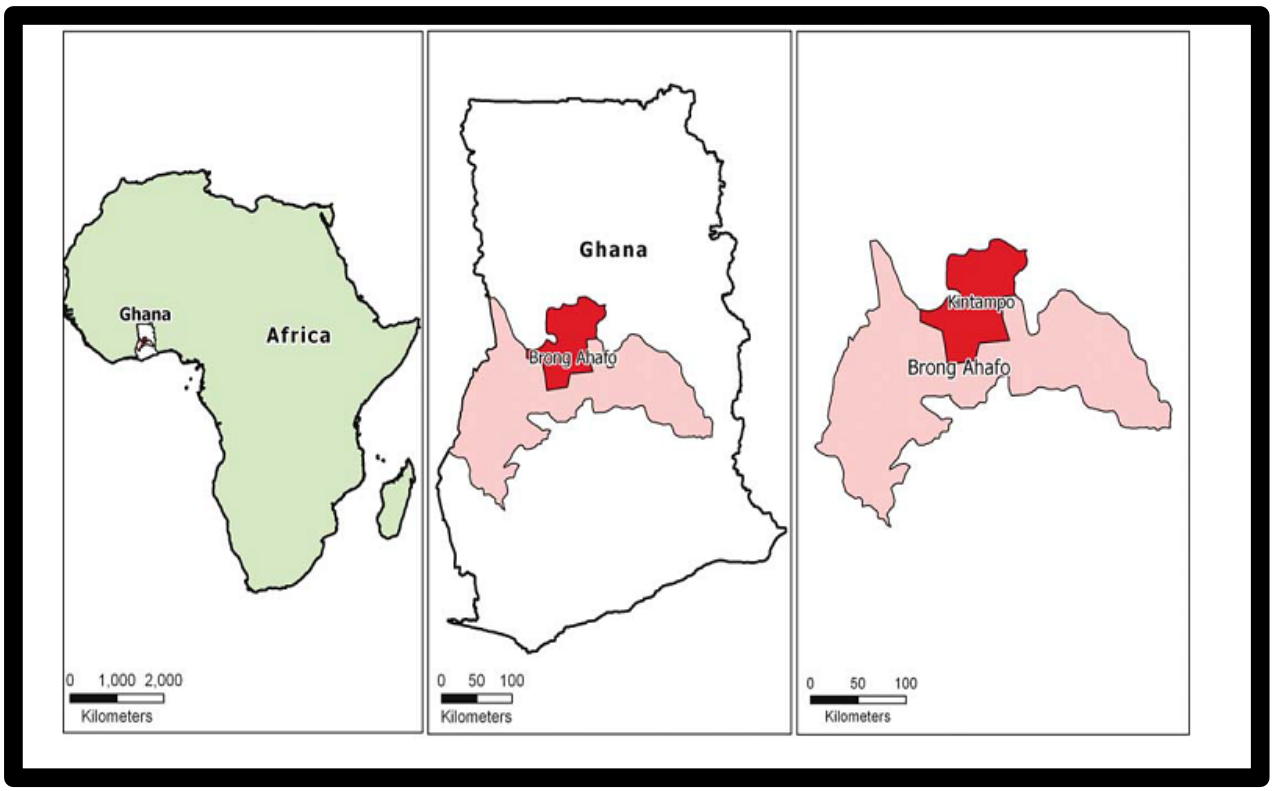

Figure 6 Map of Kintampo Districts located in the middle belt of Ghana

3.3.2 Justification of the study settings

The study site was selected based on its strategic geographical location in the centre of Ghana with a population representative of the general Ghanaian population. Ghana operates a decentralised system of governance with the District Assemblies having overall political responsibility for administrating their respective regions. Therefore, what happens in Kintampo North Municipality in terms of political administration is replicated across all other districts in Ghana. The Kintampo area is commonly used for public health sampling as it is considered representative of the wider Ghana population (Owusu-Agyei et al., 2012).

Mental health services in Kintampo are more highly developed than in many other districts in Ghana due to the existence of the Kintampo Health Research Centre (KHRC). The KHRC (www.kintampo-hrc.org) is one of three research institutions in Ghana established in 1994 by the MoH under the Research and Development Directorate to conduct high-quality research relevant to healthcare priorities in Ghana and pan-Africa. The KHRC has a particular focus on mental health research and has previously facilitated and supported the establishment of mental health services in the only Municipal hospital in the Municipality. The KHRC has since worked collaboratively with the Municipal hospital in the area of mental health service delivery.

The PhD candidate is an established researcher based at the KHRC. Through his research role, he has facilitated several significant mental health research projects within the Kintampo

North Municipality including the Mental Health and Poverty Project, Studies on the Epidemiology of Epilepsy in Demographic Surveillance Sites, and risk factors for schizophrenia (Ae-Ngibise et al., 2010; Ae-Ngibise et al., 2017; Ae-Ngibise, Akpalu, et al., 2015; Ae-Ngibise, Doku, et al., 2015). Further to this, the Kintampo College of Health and Wellbeing (www.cohk.edu.gh) collaborates with the Kintampo Project (www.thekintampoproject.org) as the leading national training institute for mental health professionals. A new generation of mental health workers unique to Ghana, including Clinical Psychiatric Officers (CPO) and Community Mental Health Officers (CMHO), are currently being trained through the Kintampo College of Health and Wellbeing. This training commenced in 2011 with mental health experts from the United Kingdom teaming up with their Ghanaian counterparts to facilitate annual training (www.thekintampoproject.org).

3.4 Position of the PhD candidate as a researcher

Bracketing is a method commonly used in qualitative research to identify and protect the research from the researcher's deleterious beliefs and personal opinion (Tufford & Newman, 2012). The PhD candidate's personal introspection about self-belief systems, socio-cultural values, assumptions and how these could potentially affect the interpretation of the observational findings was considered. Accordingly, potential imbalances of power between the PhD candidate and the participants, economic and social status as a student from a western university, professional training, and different Christian denominations were considered, reflected upon and bracketed. The researcher did self-examination as part of preparations for the observational study in the prayer camps. The concept of reflexivity, which included both philosophical self-reflection and methodological self-consciousness, was considered to minimise bias and protect the integrity of the research (Ghana Mental Health Authority, 2018). These measures were put in place to ensure the data collected are of good quality.

3.5 Data collection

The data collection was conducted in three phases. These phases included: (i) a quantitative survey among people living with severe mental disorders to describe functional ability due to their mental health condition; (ii) an observational study at two prayer camps to assess human rights abuses within these institutions; and (iii) IDIs /FGDs to characterise the barriers and enablers for implementing the MHA. These data collection phases are described in the following sections.

3.5.1 Study 1: Quantitative survey

3.5.1.1 Recruitment and data collection

A survey was conducted to measure the degree of disability among people with severe mental disorders including schizophrenia, bipolar disorder, and major depressive disorder. The study participants included all people already diagnosed with a severe mental illness living in the Kintampo study area. The included disorders were schizophrenia, major depression, bipolar disorders and are conceptualised in this Thesis as severe disturbances in thinking, emotion, and behaviour. A number of characteristics of people with severe mental disorders and their caregivers were collected and described in this study. This quantitative data collection was conducted within the Kintampo North Municipality and Kintampo South District using the Kintampo Health and Demographic Surveillance System (KHDSS) platform. The KHDSS, as operated by the KHRC, keeps an updated database of all the resident population within the geographical area through yearly routine census updates to record basic information such as births, migrations and deaths (Owusu-Agyei et al., 2012). Among the information routinely collected by the KHDSS platform, is household demographics as well as ownership of assets for the estimation of household socio-economic status or wealth indices.

The KHRC maintains a psychiatric case register of people living in the district (Ae-Ngibise et al., 2017; Doku et al., 2008). The psychiatric case register was established to describe the epidemiology of mental and neurological disorders as well as to serve as a basis for a district-mental health management information system. People living with mental disorders were initially identified from the risk factors for psychosis study and subsequently updated from ongoing mental health studies by KHRC and the Kintampo Municipal Hospital's psychiatric unit. Some of the people living with mental disorders, which form part of the psychiatric case register, were also referred from community psychiatric nurses and community-based surveillance volunteers in the Kintampo area. These cases have been allocated unique identification numbers by the KHDSS platform, in addition to their location details to facilitate follow-up (Doku et al., 2008). At the time of the data collection for this study, all 70 registered patients consented and were included in the study. The data collection was completed in May and June 2019.

3.5.1.2 Quantitative study instruments and validation

The WHO Disability Assessment Schedule (WHODAS-12) was used for the quantitative data collection to measure the participant's level of functional disability. The outcome variable of this study is disability. The WHODAS–12 is a validated generic assessment instrument providing a standardised method for measuring health and disability across different cultures and

populations. This tool is widely used to measure disability and functional deficiency, which is bundled with the Diagnostic and Statistical Manual of Mental Disorders (5th Edition) (Axelsson et al., 2017). This instrument is noted for its good psychometric properties such as sound reliability and item-response characteristics (Badu et al., 2021; Üstün, Chatterji, et al., 2010).

The WHODAS-12 provides an overall measure of global disability, with higher scores indicating a higher level of disability. Each item is answered using a five-point Likert scale, with response options ranging from 1 (Kaunonen et al.) to 5 (extreme/ cannot do) (Carlozzi et al., 2015). The simple scoring method, as outlined in the WHODAS-12 manual, was employed to calculate an overall disability score for each participant. This process involved summing all items together (Üstün, Kostanjsek, et al., 2010), resulting in a total score ranging from a possible 12 to 60. If a participant was missing only one item across the whole scale, the mean value across all other items answered by that participant was used to represent the missing value. A total WHODAS-12 score was not calculated for participants missing more than one item. The WHODAS-12 has previously been used in the Kintampo study area among people with psychosis and has been translated into the widely spoken local language (Antwi-Bekoe et al., 2009).

In addition to the WHODAS-12 instrument, baseline demographic data was collected for descriptive analysis. A brief survey was also conducted among persons with severe mental disorders and their caregivers to assess their disability status and their mental health support expectations. This survey assessed the progress of implementing the MHA from the perspectives of mental health service users and carers. A study-specific survey was conducted to assess both participants' access to support from the available mental health stakeholders in Ghana and their knowledge of the MHA. Ten and 11 items were used to assess participants' access to support and their knowledge of the MHA, respectively (see Appendix A).

Face and content validation techniques were applied to determine whether the questionnaire measures what it was intended to measure. A team of senior researchers and language experts with several years' experience in questionnaire design for data collection through the Kintampo Health Demographic Surveillance System (KHDSS) were engaged at an early stage of the questionnaire development to evaluate individual questionnaire items. The experts evaluated each item from the perspective of variation, meaning, redundancy, flow, timing, and acquiescence. Whilst English is the official language, Ghana is a multilingual country with more than seventy ethnic groups with their own distinct languages, albeit many ethnic groups are mutually intelligible. The senior researchers further evaluated each item linguistically and analytically to determine if the questions constructed measure what is supposed to be measured based on the study goals. Feedback from the research team was incorporated into the final questionnaire. The questionnaire validation process conducted by the team of senior

researchers was done to ensure that the questions are reasonably clear and unambiguous to comprehend from respondents' perspective. Participants responded to each item as either "yes", "no" or "don't know". Two additional open-ended questions were also included to assess why participants were not registered on the National Health Insurance Scheme (NHIS) or the Livelihood Empowerment Against Poverty (LEAP) program.

3.5.1.3 Quantitative data management and analysis

The Research Electronic Data Capture (REDCap), a web-based application for the capture of clinical research data, was used for the quantitative surveys (Patridge & Bardyn, 2018). REDCap is a self-sufficient and secure database used for routine data entry across multiple distinct time points and can be readily exported to other statistical programs for data analysis. The statistical analysis for the quantitative data was performed using SAS v9.4 (SAS Institute, Cary, North Carolina, USA). Descriptive statistics, including means, standard deviations, medians and interquartile ranges for continuous variables and frequencies and percentages for categorical variables, were calculated for all outcomes and patient characteristics.

Due to the descriptive nature of this study and the skewed distribution of the WHODAS-12 scores, the non-parametric Wilcoxon rank sum test (Haynes, 2013; Natarajan et al., 2012) was used to assess differences in WHODAS-12 scores between the following characteristics: gender (male vs. female), employment status (employed vs. not employed), and marital status (partnered vs. not partnered). The researchers deemed these demographic characteristics as clinically important factors relative to mental illness as previously reported elsewhere (Preoţiuc-Pietro et al., 2015). Due to the small number of participants in some of the diagnostic categories, differences based on diagnosis were not assessed. The null hypothesis for the Wilcoxon rank sum test is that the distributions between the two groups are similar. A two-sided alpha level of 5% was used, meaning that for comparisons with a p-value <0.05 the null hypothesis can be rejected and conclude a statistically significant difference in the distribution of WHODAS-12 scores between the two relevant groups. As the Wilcoxon rank sum test is often referred to as a comparison of medians (Haynes, 2013; Natarajan et al., 2012), the median and interquartile range for each group are also presented to assist in the interpretation of the results. It was also originally intended to assess the association between the above characteristics and participant's knowledge of the MHA. However, as only two participants were aware of the MHA, no such detailed comparisons were possible; and thus, only differences in the WHODAS-12 scores were explored. Chi-squared tests were conducted to assess the association between diagnosed mental illness, services received and gender of research participants. Statistical analysis was performed using SAS v9.4 (SAS Institute, Cary, North Carolina, USA).

3.5.2 Study 2: Observational study at prayer camps

An observational fieldwork study was conducted to investigate treatment schemas and patterns of behaviour of patients seeking spiritual healing and also the extent of any human rights abuses in two separate prayer camps. Also, the study explored the degree of collaboration between prayer camps and formal mental health service providers. The majority of prayer camps in Ghana are owned and administered by the Church of Pentecost.

3.5.2.1 Study sites for observation

The camps were situated in Ho in the Volta Region, and Cape Coast in the Central Region of Ghana. These two study sites were purposively selected because both prayer camps had a system of collaborating with conventional mental health service providers in managing people with mental illness including having a two-way referral system in place. Also, apart from having access to the patients, both camps had residential facilities for patients. The aim was to assess a model with the potential to strengthen collaboration between faith-based healing and conventional health service providers. Participants included all patients and prayer leaders attending these camps for spiritual healing. Attendees who opted out were not observed and, thus not included in the analysis. Observations were made for eight hours at both prayer camps, making a total of 16 hours of observations. Faith-based healers are predominantly Pentecostal or Charismatic in dogma in Ghana, hence healing is considered an important part of their religious expression. Although such churches are required to be registered with the Ghana Pentecostal and Charismatic Council, the prayer camps (also called healing centres) are not registered separately as healthcare facilities, primarily because their activities may also include prayers for non-health problems. This may present a challenge for regulating and monitoring the activities of these practitioners.

The observations were carried out in the prayer camps in June 2019 by three observers. These observers included the PhD student (Psychiatry) from the University of Newcastle, an established mental health researcher trained in psychology and epidemiology. The other observers included a graduate student of Biomedical Sciences from the University of Health and Allied Sciences, Ghana and a Registered Mental Health Nurse. All observers were accredited Mental Health First Aiders and had considerable expertise in qualitative research.

As a procedure, a behavioural checklist (Appendix J) was used to record each instance of listed behaviours during eight hours with a 1-hour break. This checklist outlined the procedures that were to be followed before, during and after the observation. The unstructured nonparticipant observation was carried out independently by two observers on a typical day

within the prayer camp. Interviews were conducted as part of the observation with the two leaders of the prayer camps and two patients, one each from the camps.

3.5.2.2 Prayer camp one

Prayer camp one started operation in the mid-1980s under the stewardship of the Church of Pentecost. The General Overseer and Apostle have the overall responsibility for the Pentecostal Church in Ghana. The Area Head of the Church of Pentecost for the Volta Region is responsible for the administration of all Pentecostal Churches' and subsidiaries within the region, including prayer camp one. The camp's internal governance is provided through a clerical executive leadership group ordained by the Pentecost Church and supported through a system of sub-committees for operational matters such as catering, accommodation, media, fasting and prayer.

With its capital in Ho, the Volta Region is located to the west of the Republic of Togo and the east of Lake Volta. There are currently 25 Administrative Districts, the region is multi-ethnic and multilingual, including Ewe, Guan, and Akan peoples. The 2021 General Population and Housing census identified a population of 1,649,523 occupying an area of approximately 20,570 km^2 (Ghana Statistical Service, 2021). The Volta Region has a total of 326 health institutions. Of these, the Ghana public-funded Health Service administers two hundred and forty-two (242), 18 are Mission owned, one facility is Government-affiliated and 65 are privately owned. Many of the GHS run health centres were community-initiated (Ghana Health Service, 2019). The only specialised psychiatric facility in the region is located in the regional hospital in Ho.

3.5.2.3 Prayer camp two

Prayer camp two was founded in the late-1980s as a spiritual healing centre for people seeking help in all aspects of life. Prayer camp two is located in Cape Coast the capital of the Cape Coast Metropolitan District and Central Region of Ghana. Overlooking the Gulf of Guinea, Cape Coast is bounded by four administrative regions including the Western, Eastern Ashanti and Greater Accra. The Central region is renowned for its many elite higher education institutions and tourism. This region occupies a surface area of about 9,825 km2 with a population of 2,859,821 with Akan and Fante as its main language (Ghana Statistical Service, 2021).

Prayer camp two is an independent organisation with its origin in the Pentecostal Church of Ghana. The prayer camp is led by a spiritual leader who is referred to by the followers as a ‘prophet’. The camp’s religious leaders are appointed and ordained by the spiritual leader.

Apart from the camp's primary spiritual mandate, it also accommodates people with various health problems including mental ill-health.

Although the two prayer camps originate from within the same Christian denomination, there are significant differences between them in terms of governance. The head pastor of prayer camp one reports to the area head of the Pentecostal Church hierarchy with significant governing structures, while the prayer camp two leader sees himself as a prophet leading a group of disciples; decision making is the sole responsibility of the prophet.

3.5.3 Study 3: In-depth interviews and focus group discussion

During the qualitative data collection component of the study, face–to–face IDIs and FGDs were conducted with purposively sampled stakeholders in the Kintampo North Municipality of Ghana. These participants were selected based on their strategic role in relation to the new mental health reforms. Strategically, the heads (or head nominee) of institutions that play some role in mental health were selected for the interviews. The Ghana Government web portal was utilised to identify and provide business contact details for department and agency heads with responsibility for operationalising the MHA. Likewise, relevant non-government organisation heads were identified and contacted via their individual organisation websites. A letter explaining the intend of the research and inviting their participation was sent directly to the relevant department or agency head. All invited (38 participants) agreed to interview. Interviews were facilitated face-to-face where possible or via phone and completed during June and July 2019. Where necessary, points of clarification were addressed through further phone contact with the relevant participant. The interviews explored the participants' knowledge about the barriers and enablers for implementing the MHA and their perspectives on the future of TFHs in relation to the new mental health reforms. Following district level data collection, individual IDIs were conducted with key stakeholders from both the regional and national levels. The focus of these interviews was to assess the progress of implementation of the MHA from the regional and national perspectives.

A list of the study participants and job roles is provided in Table 12. The study participants were drawn mainly from Government policymakers and implementers, conventional and TFHs, community opinion leaders, NGOs and mental health service users, and carers across all sixteen administrative regions in Ghana.

3.5.4 Qualitative data collection strategies

The PhD candidate and a trained Research Officer (RO) with experience in qualitative research techniques conducted all the FGDs and IDIs. These interviews explored in detail the barriers and enablers of implementation of the MHA. The study was intended to document the

barriers and enablers as well as to evaluate the role of TFHs as key actors involved in the implementation of the mental health reforms that were introduced in Ghana in 2012. This data collection strategy is useful for assessing socio-cultural factors and belief systems that may present barriers or enablers to implementing mental health reforms. All FGD and IDI participants gave both verbal and written informed consent, including permission for the interviews to be audio recorded. The PhD candidate and a RO were involved in each of the FGDs, one moderated the discussions, and the other took notes.

3.5.5 Qualitative data management and analysis

All qualitative data collected through the IDIs and FGDs were digitally recorded (with prior permission and approval from participants) and transcribed verbatim by trained and experienced qualitative researchers. Professional translators available through the KHRC conducted and translated interview transcripts from Twi to English and provided back-translation where necessary, in line with ethnographic research methodology (Atkinson & Morriss, 2017). These transcripts were exported into NVivo 11 (QSR International Pty Ltd. Version 11, 2015) for analysis. A five-stage analysis framework was used for the qualitative data analysis. This approach involves a five-step process including familiarisation with the transcripts, developing a coding frame, considering emerging themes from the transcripts, charting and mapping the responses and interpretation of the results (Gale et al., 2013; Spencer & Ritchie, 2002). The Framework method is appropriate for thematic analysis of qualitative data with the intention to compare and contrast data across themes and participant groups. A summary description of the steps involved in the Framework method for analysing qualitative data is presented in Figure 7 (Kennedy et al., 2008).

Thematic analysis (both inductive and deductive) was conducted (Braun et al., 2012) for the qualitative data collected. This approach systematically identifies, organises, and offers insight into patterns of meaning (themes) across the individual transcripts. For the data analysis, the structure was derived from the data (inductive approach), while also making use of the WHO HSBB and LHPS frameworks (Figures 3, 4 and 5) as well as themes identified by earlier studies about barriers to implementing mental health policies (deductive approach). Factors affecting the implementation of the MHA as well as the impact of the introduction of the Act on improved citizenship (rehabilitation services and support for family caregivers), and human rights (discrimination, stigma and ill-treatment) protections for people living with mental disorders were evaluated.

Stage 1: Familiarisation

Immersion in the raw data (or typically a pragmatic selection from the data) by listening to tapes, reading transcripts, etc., in order to list key ideas and recurrent themes.

Stage 2: Identifying a thematic framework

Identify all the key issues, concepts and themes by which the data can be examined and referenced. This is carried out by drawing on a priori issues and questions derived from the aims and objectives of the study as well as issues that recur in the data.

Stage 3: Indexing

Applying the thematic framework or index systematically to all the data in textual form by annotating the transcripts with codes from the index, usually supported by short text descriptors to elaborate the index heading.

Stage 4: Charting

Rearranging the data according to the appropriate part of the thematic framework to which they relate, and forming charts.

Stage 5: Mapping and Interpretation

Using the charts to define concepts, maps the range and nature of phenomena, create typologies and find associations.

Figure 7: Five stages of data analysis in the framework approach (adapted from Kennedy et al., 2008)

3.5.6 Data protection, quality control and trustworthiness

For the quantitative component of the study, measures were put in place to ensure a high level of data quality for the community survey before and during data collection and entry. The data collection tools were pilot tested across a representative sub-group of stakeholders. A two-day intensive training session was conducted for the RO who participated in the data collection.

To ensure trustworthiness of the qualitative data, five transcripts, representing 10% of the transcripts overall, were randomly sampled and independently coded by the research team members to ensure validity of the qualitative data. This involved simultaneously coding the same selected transcripts by different research team members to check for concordant and divergent views for resolution. Divergent views were reconciled through discussions among team members to arrive at a consensus.

The framework analysis approach was employed for the qualitative data management because it also allowed for data analysis to begin during the data collection phase. Triangulation and member checks (participant validation or review of responses transcribed and feedback), data inquiry audit, which required an outside person to review and examine the research process to ensure the stability of data over time, were adopted to ensure the validity and authenticity of the data (Creswell, 2013). Data triangulation (the practice of using multiple sources of data or multiple approaches to analysing data to enhance the study credibility), across five separate data sources (key Government leaders, NGOs, community opinion leaders, mental health service providers and TFHs) was performed to reduce potential bias. Data analysis and interpretation were subjected to peer review by staff from the KHRC not otherwise involved in the conduct of the study.

The following framework Figure 8 was used to enhance the trustworthiness of the qualitative data. The process involves four steps including;

(i) credibility; triangulation and member checking of transcripts for consistency,

(ii) dependability; data inquiry audit, which requires an outside person to review and examine the research process to ensure stability of data over time,

(iii) transferability; contextual generalisation based on the use of purposive sampling for the data collection; and

(iv) confirmability; which provides an audit trail, highlighting every step of data analysis that was made in order to provide a rationale for decisions made with respect to the analysis procedure (Creswell, 2013; Creswell & Poth, 2016).

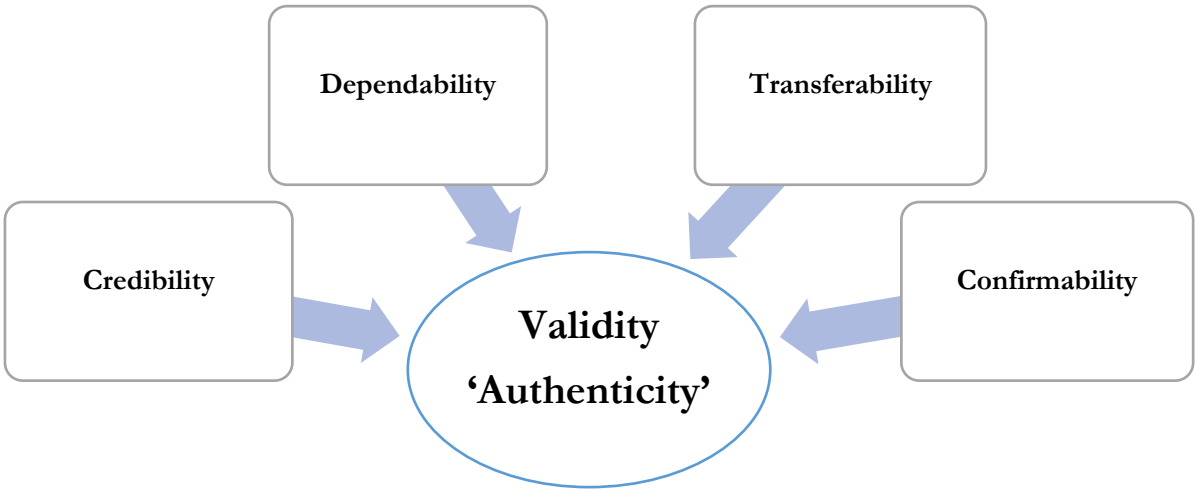

Figure 8 Framework for ensuring data authenticity (Creswell, 2013; Creswell & Poth, 2016).

3.6 Ethical considerations and approvals

The scientific and methodological soundness of the research protocol was assessed by the University of Newcastle's School of Medicine and Public Health, and the KHRCs Scientific Review Committees (SRC). Ethical approval was subsequently obtained from the Human Research Ethics Committee (HREC: H-2018-0424), at the University of Newcastle, Australia and the KHRC Institutional Ethics Committee (KHRC IEC/2018-25) (Appendix F), in Ghana. Additionally, permission was obtained from the GMHA for the participation of the RMHC in the study. The study protocol, data collection tools, consent forms and participant information sheets were all presented to these overseeing institutions for consideration as part of the ethics approval process. The study was conducted in the highest ethical consideration of voluntarism and participants' willingness to participate in the study.

3.7 Chapter Summary

The study design, the methodology and the data sources employed in this Thesis have been described in this chapter. Chapter 4 presents the study findings about knowledge and awareness of the MHA on the part of people living with severe mental illness. The survey also reports on disability among people living with severe illness in the Kintampo area of Ghana

Chapter 4 Disability among people with severe mental disorders

4.1 Introduction and purpose of the quantitative study

Chapter 4 reports the results of the quantitative study that investigated the degree of disability among people with mental illness. The survey was conducted to gather baseline data for future measurement of the impact of the MHA implementation while also assessing the level of knowledge of the MHA from service users and their family and carers. Assessing the knowledge of the MHA and its impact on service improvement from user perspective was intended to gauge the penetration of the MHA with the goal of informing advocacy strategies. The specific aims of the quantitative study were to:

1. Describe the demographic and clinical characteristics of participants;
2. Assess participants' access to support from stakeholders;
3. Assess participants' knowledge of the MHA;
4. Assess participants' level of self-reported disability;
5. Explore differences in levels of disability by important characteristics.

4.2 Demographic and clinical characteristics

Seventy participants completed both surveys within the study period. Table 3 details the demographic characteristics of the participants. The mean age was 38 years, and the majority of participants were male (57%). Almost one-third (31%) of participants had Junior High or Middle School education, more than half (57%) of the participants had never been married, and 83% of the participants were not in any employment. Again, more than half of the study participants (57%) were living independently in their communities compared to 43% who needed assistance from family members.

Table 3 Participant demographic characteristics

Variable		**Total (%) (N=70)**
Gender	Male	40 (57.0)
	Female	30 (43.0)
Education	None	9 (13.0)
	Primary	19 (27.0)
	JH/Middle school	22 (31.0)
	Secondary	19 (27.0)
	Tertiary	1 (1.4)
Relationship status	Single	40 (57.0)
	Married	17 (24.0)
	Living together	1 (1.4)
	Widowed/separated/divorced	12 (17.0)
Religious orientation	None	3 (4.3)
	Christian	43 (61.0)
	Islam	23 (33.0)
	Traditional African	1 (1.4)
Ethnic group	Akan	17 (24.0)
	Northern descent	39 (56.0)
	Ga/Ewe	2 (2.9)
	Mo	9 (13.0)
	Other	3 (4.3)
Employment	Employed	12 (17.0)
	Unemployed	58 (83.0)
Living situation	Independent in the Community	40 (57.0)
	Assisted Living	30 (43.0)
Community name	Ampoma	1 (1.4%)
	Dawadawa	2 (2.9%)
	Kadelso	3 (4.3%)
	Kawampe	2 (2.9%)

Variable		Total (%) (N=70)
	Kintampo	57 (81%)
	Kobeda No 2	2 (2.9%)
	Suronuase	1 (1.4%)
	Yapare	1 (1.4%)
	Zabrama	1 (1.4%)
Owner of a current residence	Yes	8 (11.0%)
	No	11 (16.0%)
	Joint ownership	51 (73.0%)
Age	n	70
	mean (SD)	38.0 (13.41)
	median (min, max)	34.0 (17.0, 85.0)
	median (Q1, Q3)	34.0 (30.0, 48.0)
No. of years spent studying	n	70
	mean (SD)	8.7 (5.1)
	median (min, max)	9.5 (0.0, 20.0)
	median (Q1, Q3)	9.5 (5.0, 13.0)

Table 4 presents the diagnosis of participants. The most common diagnosis was schizophrenia/psychosis (63%), followed by bipolar disorder (13%) and substance-induced psychosis (11%). The mean time since diagnosis was 142.24 months. Over one-third of participants had a family history of mental illness (37%), with a sibling the most frequently reported family member with a mental illness (19%). Of the three participants who selected 'other' as their family member, one reported a child, one a first cousin and one an uncle. Forty-one percent of participants who were available to work were not working due to lack of employment opportunities.

Chi- square analysis was conducted to explore the association between diagnosed mental illness and the gender of participants. From the chi-square analysis, there was insignificant association at 5% significance between diagnosis of mental illness and gender of participants (Table 4).

Table 4 Association between diagnosed mental illness and gender of participants

Variable	Total (%) (N=70)	Male (N=40)	Female (N=30)	p-value
DSM diagnosis of mental illness				
Bipolar disorder	9 (13.0)	4	5	0.257
Substance-Induced Psychosis	8 (11.0)	7	1	
Mental Sub-Normality	5 (7.1)	3	2	
Depression	4 (5.7)	1	3	
Schizophrenia/Psychosis	44 (63.0)	25	19	
Case available to work				
Yes	29 (41.4)	18	11	0.484
No	41 (58.6)	22	19	
Family history of mental illness				
Yes	26 (37.0)	17	9	0.284
No	44 (63.0)			
Family member with mental illness				
Parent	5 (7.1)	3	2	0.590
Sibling	13 (19.0)	8	5	
Grandparent	5 (7.1)	3	2	
Other	3 (4.3)	3	0	
Not applicable	44 (63.0)	23	21	
Time since diagnosis (months)				
n	70			
mean (SD)	142.24 (99.96)			
median (min, max)	119.00 (11.00, 431.00)			
median (Q1, Q3)	119.00 (59.00, 203.00)			

Table 5 details the treatment and care participants had received. All participants had sought treatment at some time, with the vast majority having also sought traditional or faith-based treatment (86%). The most common psychiatric treatment currently being received was outpatient/community psychiatric care (69%). The mean time since participants last saw a health worker was 31.37 days.

Chi-squared analysis was also conducted to explore the association between health services received and gender of the participants. This analysis demonstrates no significant association between healthcare services received and gender of the research participants (Table 5).

Table 5 Association between participant gender and details of treatment and care received

	Total (%) (N=70)	Male (N=40)	Female (N=40)	p-value
Ever Sought treatment				

Yes	70 (100.0)	40	30	
Sought traditional/faith-based treatment				
Yes	60 (86.0)	32	28	0.115
No	10 (14.0)	8	2	
Current psychiatric status:				
Not receiving formal psychiatric treatment	12 (17.0)	9	3	
Outpatient/community psychiatric care	48 (69.0)	27	21	0.220
Receiving both traditional/faith-based & orthodox treatments	9 (13.0)	3	6	
Receiving healing from traditional/ faith-based only	1 (1.4)	1	0	
Time since last seen by health worker (days)				
n	70			
mean (SD)	31.37 (63.45)			
median (min, max)	0.00 (0.00, 296.00)			
median (Q1, Q3)	1.0 00, 0.00			

4.3 Access to support from stakeholder agencies

Details of support received from key service agencies by participants in the previous 12 months is presented in Table 6. Support in this context is in the form of benefits received from key agencies such as the District Assembly Common Fund for people with psychosocial disabilities, health user advocacy groups, LEAP from social welfare, access to community rehabilitation services and legal services as well as being registered with the NHIS.

One-third (33%) of participants had accessed support from any agency in the previous 12 months. The majority of participants were registered on the NHIS (83%), with over half of all participants being active members of the NHIS (71%). Among participants who did not register with the NHIS, lack of money was the main reason cited (97%). The annual subscription for registering on the insurance is about US$ 5.0. Only 4% of participants were registered on the LEAP program, with the main reasons for not registered being "change of Government/not yet received" (42%). Also, 49% of participants indicated they received support in terms of education and facilitating the acquisition of psychotropic medication from the mental health service user advocacy group. Only 4% of research participants indicated that they had received support from the District Assembly or local council. No community rehabilitation services were available in the area for people with mental disorders. There were associations between participant gender and accessing help in the last 12 months (p=0.002), registering and maintaining active membership on NHIS scheme (p=0.030).

Table 6: Table 6 Associations between participant gender and support received from stakeholders in the previous 12 months

	Total (%) (N=70)	Male (N=40)	Female (N=30)	p-value
Accessed help in the past 12 months				**0.002**
Yes	23 (33.0)	7	16	
No	47 (67.0)	33	14	
Support from District Assembly				0.394
Yes	3 (4.0)	1	2	
No	67 (96.0)	39	28	
Mental Health user advocacy groups				0.118
Yes	34 (49.0)	16	18	
No	35 (51.0)	23	12	
Missing	1	1	0	
Access support from Social Welfare				0.181
Yes	22 (31.0)	10	12	
No	48 (69.0)	30	18	
Community rehabilitation services available				
No	70 (100.0)	40	30	
Able to access legal services				
No	70 (100.0)	40	30	
Registered on the NHIS				0.170
Yes	58 (83.0)	31	27	
No	12 (17.0)	9	3	
Active member of NHIS				**0.030**
Yes	41 (58.6)	19	22	
No	29 (41.4)	21	8	
Registration on NHIS done free of charge				**0.017**
Yes	16 (22.9)	5	11	
No	54 (77.1)	35	19	
Reason not registered on NHIS				
Refused registration	1 (3.0)			
Lack of Money	11 (97.0)			
Registered for LEAP				0.074
Yes	3 (4.3)	0	3	
No	67 (96.0)	40	27	
Reason not registered on LEAP				
Change of govt/Not received yet	28 (42.0)	16	12	0.629
Not aware of LEAP	11 (16.0)	8	3	
Not registered	28 (42.0)	16	12	
Missing	3	3	0	

4.4 Knowledge and impact of the MHA

Participants' knowledge of the MHA is described in Table 7. Knowledge of the MHA was low, with only 3% of participants having heard of the MHA, and only 1% being aware of their rights under the MHA. None of the participants perceived the MHA to have brought about improved mental healthcare in Ghana.

Table 7 Knowledge of the MHA

Variable		**Total (%) (N=70)**
Heard about the MHA	Yes	2 (2.9)
	No	67 (96.0)
	Don't Know	1 (1.4)
MHA aim is to provide mental healthcare	Yes	1 (1.4)
	No	4 (5.7)
	Don't Know	65 (93.0)
Aware of rights provided by MHA	Yes	1 (1.4)
	No	4 (5.7)
	Don't Know	65 (93.0)
Helped in creating access to mental health services	No	5 (7.1)
	Don't Know	65 (93.0%)
Reduction in treatment gap	Yes	1 (1.4%)
	No	4 (5.7%)
	Don't Know	65 (93.0%)
Availability of psychotropic medicine	Yes	1 (1.4%)
	No	4 (5.7%)
	Don't Know	65 (93.0%)
Know where to report abuse/violation of rights	Yes	2 (2.9%)
	No	3 (4.3%)
	Don't Know	65 (93.0%)
Able to complain about abuse of rights	Yes	1 (1.4)
	No	4 (5.7)

	Don't Know	65 (93.0)
MHA has lessened financial burden	Yes	1 (1.4)
	No	4 (5.7)
	Don't Know	65 (93.0)
Clearing the streets	No	5 (7.1)
	Don't Know	65 (Local Governance Act 936)
MHA brought about improved mental healthcare	Yes	0
	No	5 (7.1)
	Don't Know	65 (93.0)

Figure 9 displays participants' ratings of their overall health in the previous 30 days. Almost half of participants rated their overall health as moderate (42%), while just under one-third reported their health as good, 15.9% as very good and 11.5% as bad.

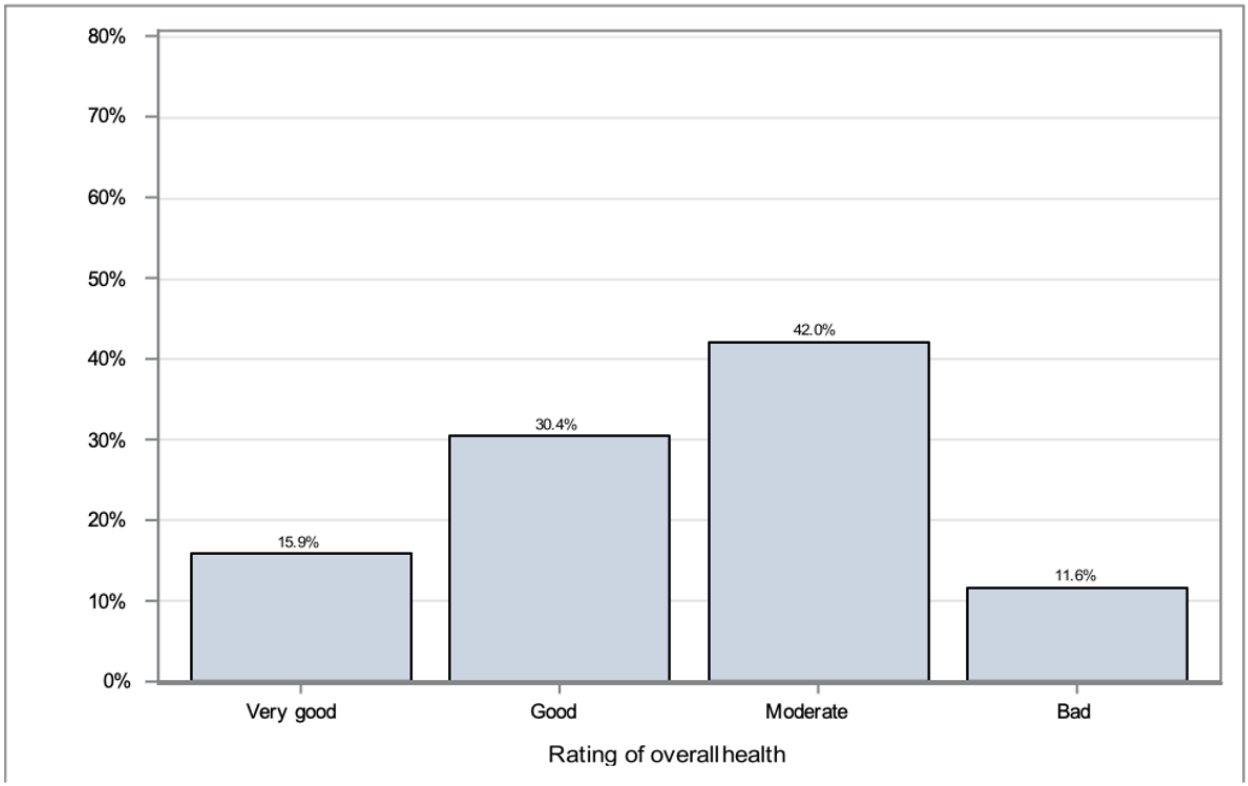

Figure 9 Participants' rating of their overall health in the past 30 days

4.5 Self-reported disability

The WHODAS-12 was used to assess the functional ability of people diagnosed with severe mental illness in the study area. Table 8 presents participant responses to the WHODAS-12 questionnaire. The majority of the participants do not have problems walking a distance of about one kilometre (59%), washing their bodies or self-care with little or no supervision (52%; 36/70), or getting dressed (57%; 39/70). Also, most of the participants were able to deal with people they did not previously know (46%; 32/70) compared with maintaining social connections or friendship (31%; 22/70). Twenty percent of the participants could not maintain friends. Less than half (34% 24/70) of the participants' mental disorders did not affect their daily activities. The rest of the participant reported that they experienced mild to extreme functional disability due to a mental disorder. These participants were a medium functioning group.

Missing data was minimal for the WHODAS-12 with only two participants missing one item each. These two items were getting dressed and washing your whole body.

Table 8 Participant responses to the WHODAS-12

WHODAS Item		**Total (%) (N=70)**
Standing for long periods such as 30 minutes?	None	51 (73.0%)
	Mild	8 (11.0%)
	Moderate	7 (10.0%)
	Severe	2 (2.9.0%)
	Extreme cannot do	2 (2.9.0)
Taking care of your household responsibilities?	None	32 (46.0)
	Mild	13 (19.0)
	Moderate	18 (26.0)
	Severe	5 (7.1)
	Extreme cannot do	2 (2.9)
Learning a new task, for example, learning how to get to a new place?	None	29 (41.0)
	Mild	15 (21.0)
	Moderate	18 (26.0)
	Severe	6 (8.6)
	Extreme cannot do	2 (2.9)
How much of a problem did you have joining in community activities	None	28 (40.0)
	Mild	13 (19.0)
	Moderate	18 (26.0)
	Severe	8 (11.0)
	Extreme cannot do	3 (4.3)
How much have you been emotionally affected by your health problems?	None	18 (26.0)
	Mild	13 (19.0)
	Moderate	23 (33.0)
	Severe	14 (20.0)
	Extreme cannot do	2 (2.9)

WHODAS Item		Total (%) (N=70)
Concentrating on doing something for ten minutes?	None	23 (33.0)
	Mild	18 (26.0)
	Moderate	20 (29.0)
	Severe	8 (11.0)
	Extreme cannot do	1 (1.4)
Walking a long distance such as a kilometre [or equivalent]?	None	41 (59.0)
	Mild	19 (27.0)
	Moderate	7 (10.0)
	Severe	1 (1.4)
	Extreme cannot do	2 (2.9)
Washing your whole body?	None	36 (52.0)
	Mild	12 (17.0)
	Moderate	14 (20.0)
	Severe	6 (8.7)
	Extreme cannot do	1 (1.4)
	Missing	1
Getting dressed?	None	39 (57.0)
	Mild	11 (16.0)
	Moderate	14 (20.0)
	Severe	4 (5.8)
	Extreme cannot do	1 (1.4)
	Missing	1
Dealing with people you do not know?	None	32 (46.0)
	Mild	12 (17.0)
	Moderate	15 (21.0)
	Severe	11 (16.0)
Maintaining a friendship?	None	22 (31.0)
	Mild	18 (26.0)
	Moderate	16 (23.0)

WHODAS Item		Total (%) (N=70)
	Severe	14 (20.0)
Your day to day work?	None	24 (34.0)
	Mild	21 (30.0)
	Moderate	17 (24.0)
	Severe	7 (10.0)
	Extreme cannot do	1 (1.4)

Table 9 details participants mean and median overall raw score, as well as the mean and median number of days over the past 30 days participants reported: (i) any difficulties; (ii) being unable to carry out usual activities or work because of any health condition; and (iii) cutting back or reducing usual activities or work because of any health condition. As shown in Table 10, the WHODAS-12 raw scores ranged from 12 to 56 (out of a possible 60), with a mean of 24.50 and a median of 23.

Table 9: Overall WHODAS-12 scores and ratings

		Total (N=70)
WHODAS-12 total raw score	n	70
	mean (SD)	24.50 (11.02)
	median (min, max)	23.00 (12.00, 56.00)
	median (Q1, Q3)	23.00 (15.00, 31.00)
Number of days the difficulties were present	n	70
	mean (SD)	5.37 (9.85)
	median (min, max)	0.00 (0.00, 30.00)
	median (Q1, Q3)	0.00 (0.00, 5.00)
Number of days unable to carry out usual activity	n	70
	mean (SD)	4.24 (8.53)
	median (min, max)	0.00 (0.00, 30.00)
	median (Q1, Q3)	0.00 (0.00, 3.00)
Number of days reduced usual activity	n	70
	mean (SD)	4.39 (8.88)
	median (min, max)	0.00 (0.00, 30.00)
	median (Q1, Q3)	0.00 (0.00, 4.00)

Figure 10 displays participants' ratings of the extent to which their difficulties interfered with their daily life. As shown in Figure 8, 40% of participants indicated that their difficulties interfered moderately with their life, 25.7% as mild, 18.6% none and 15.7% as severe.

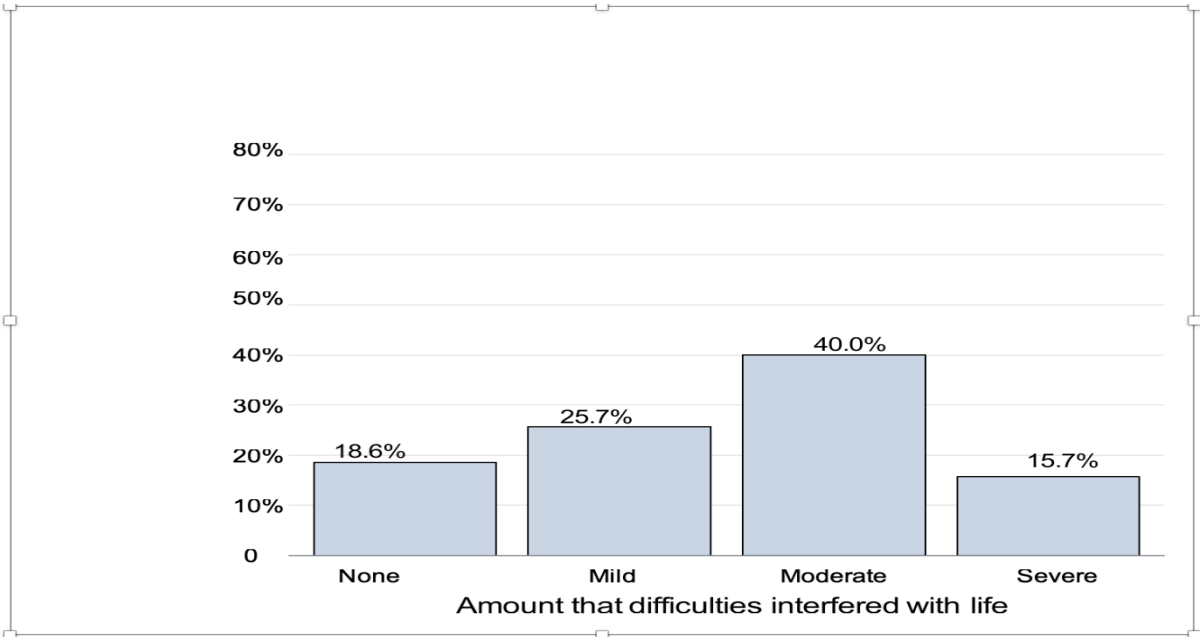

Figure 10 Participants' rating of the extent to which their difficulties interfered with their life

4.6 Differences in WHODAS-12 scores by clinically relevant features

As shown in Figure 11, the distribution of the total WHODAS-12 scores was skewed to the right. Consequently, the non-parametric Wilcoxon rank sum test was used to compare the median WHODAS-12 values on clinically important characteristics.

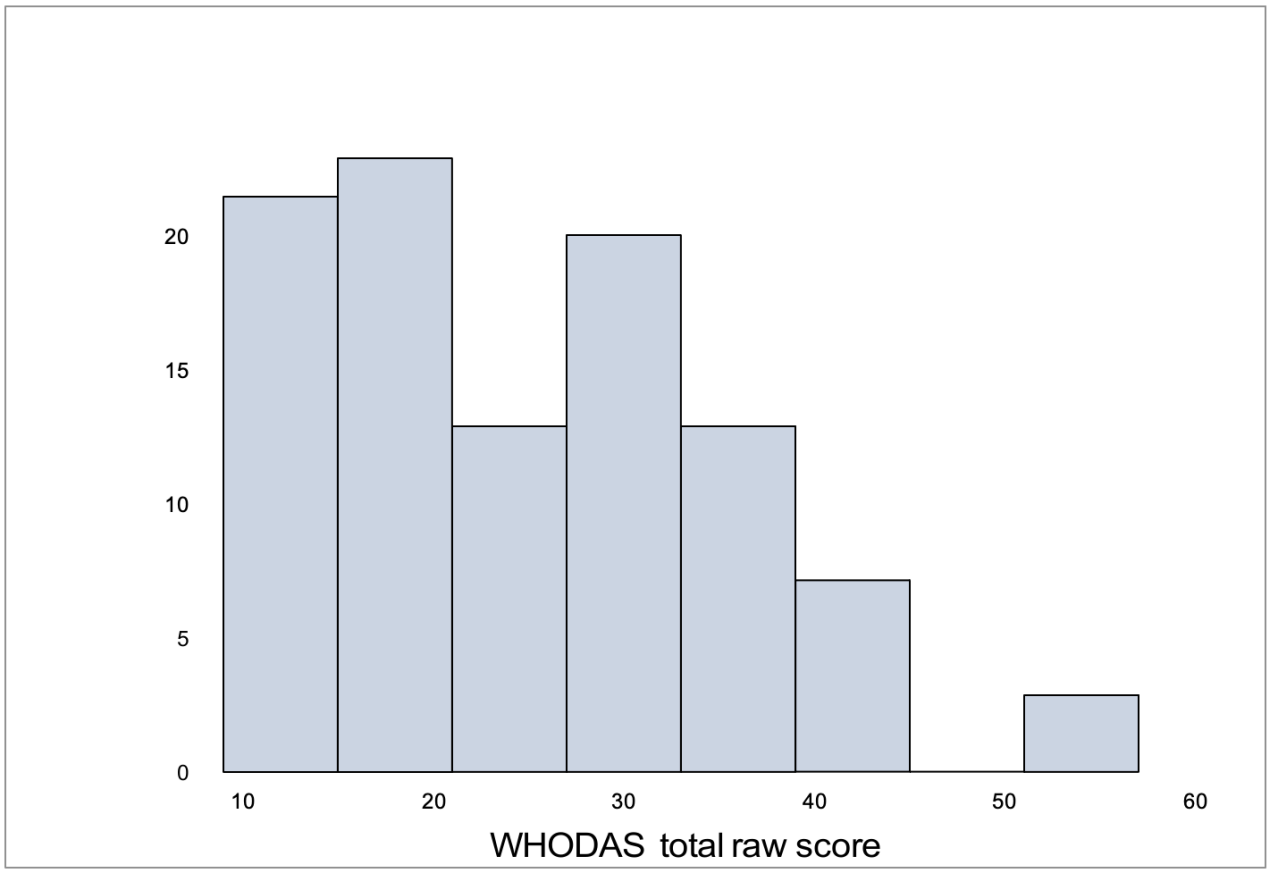

Figure 11 Distribution of total WHODAS-12 scores

Table 10 details the results from the Wilcoxon rank sum tests used to compare the distribution of the WHODAS-12 scores between: (i) males and females; (ii) employed and unemployed; and (iii) partnered and not partnered, participants. There were no significant differences in the distribution of WHODAS-12 scores for males vs. females, with the p-value for this test above 0.05. However, there were significant differences between employed vs. unemployed and partnered vs. not partnered, with the p-value for these tests being below 0.05. As can be seen in Table 10, participants who were employed had lower median WHODAS-12 scores compared to those who were unemployed (12.00 vs. 26.50); while those who were in a partnered relationship had lower median WHODAS-12 scores than those who were not in a partnered relationship (15.00 vs. 27.00).

Table 10: Results from the Wilcoxon rank sum test to identify statistically significant results

Variable		Median (Q1, Q3)	p-value
Employment status	Employed	12.00 (12.00,15.50)	<.001
	Unemployed	26.50 (16.00,33.00)	
Gender	Male	21.50 (15.00,30.00)	0.464
	Female	28.00 (15.00,34.00)	
Marital status	Not partnered	27.00 (16.00,32.50)	0.016
	Partnered	15.0 (13.00,18.00)	

Significant at p-value <0.005

4.7 Chapter summary

Chapter 4 has reported on a survey conducted among people living with severe mental disorders from Ghana. The research participants responded to questions about their daily functional ability because of their mental condition as well as their knowledge of the MHA and the resultant impact of the Act on their life.

Some of the research participants reported higher disability on the WHODAS-12 score, indicating their inability to function well daily due to the mental disorder. About 34% of the participants reported that their mental condition did not affect their daily activities, while the remainder reported mild to severe functional disability because of their mental disorder.

There was a general lack of a support network for people with mental disorders in the study sample with only a third of the participants who had access to any form of support or social protection services including the NHIS and LEAP within the previous 12 months.

People with mental disorders were generally unaware of the existence of the new MHA passed in 2012 and what it entails, especially the objective to promote mental healthcare throughout Ghana. The implication is that many people with mental disorders were not accessing or getting the needed mental health services.

This study highlights the need for stakeholders, especially central Government to scale up mental health services nationwide. Successful strategies can be adopted to overcome barriers to scaling up, such as the low priority accorded to mental health, scarcity of human and financial resources, and difficulties in changing poorly organised services. This calls for a speedy scale-up of mental health services throughout the country to ensure mental health services are accessible to all.

Chapter 5 reports the study findings of an observational study conducted in two prayer camps in Ghana in relation to human rights and the practice of faith-based healing.

Chapter 5 Human rights and faith-based healing: An observational study at two prayer camps in Ghana

5.1 Introduction

This chapter reports the findings of an observational study conducted in two prayer camps in Ghana under study 2. The chapter commences with an overview of help-seeking practices of people living with mental health problems and disorders and the factors influencing treatment options. This is followed by a discussion of the practices of TFHs. A description is provided of the current practices in two Christian prayer camps following the advent of the MHA to provide humane care including treatment and rehabilitation in the least restrictive environment including in prayer camps. The chapter concludes with a discussion of the relevance of prayer camps and recommendations for the future governance, role and delivery of care within the prayer camps for a holistic and sustainable mental healthcare system in Ghana.

The environment of both prayer camp one and two looked well maintained, ordered, and organised. There were musical instruments for music ministration and spacious purpose-built structures, serving as prayer meeting centres. Both camps appeared calm, peaceful, and orderly with options for worship, including music ministration and prayer spaces. Approximately, 151 participants made up of 85 worshipers from prayer camp one and 66 worshipers from prayer camp two were observed as part of the ethnographic study.

5.2 The popularity of prayer camps in Ghana

There is a poor distribution of orthodox health facilities and other resources for mental healthcare in Ghana (Roberts et al., 2014a), especially a shortfall in the mental health workforce (Ofori-Atta, Read, & Lund, 2010). On the other hand, over 7000, Christian groups have been registered in Ghana (Assimeng, 2010). Several others are unregistered and unaccounted for, and many of these Christian organisations operate prayer camps that are managing people with mental illness. These organisations perform various roles in the churches, including providing counselling services. Therefore, it can be argued that the clergy from these faith-based camps may help to address the large treatment gap that exists due to the under-resourcing of orthodox health facilities.

Although Government is required to provide resources for implementing the MHA, this has not happened, and there is little evidence of commitment to implement the MHA. In addition to the

lack of resources for full implementation of the MHA, entrenched cultural beliefs and weak state capacity to regulate the activities of the prayer camps have also limited progress. It has, therefore, been suggested that the lack of mental health workers in Ghana could be supplemented by the services offered in prayer camps, provided prayer camp healers were trained to identify, assess and refer cases of mental disorders that are beyond their capacity to the appropriate health facilities (Asamoah et al., 2014). There have been ongoing formal and informal discussions regarding whether prayer camps should be part of the mental healthcare system due to concerns about human rights abuse. However, since the MHA recognises TFHs as frontline community mental health workers, the contribution made by prayer camps could be formalised as part of a more wide-ranging mental health workforce plan.

One of the barriers to collaboration between orthodox practitioners and Christian practitioners has been distrust regarding the latter's involvement in delivering mental health services in Ghana (Asamoah et al., 2014). This has inevitably hampered effective integration of faith-based healing into mainstream mental healthcare and a barrier to implementing the MHA.

In this observational study, the prayer camp leaders were not opposed to collaboration with orthodox health services, mainly referring patients to the conventional health facilities for treatment. This was also observed in previous research investigating the conceptualisation and treatment of mental disorders by neo-prophetic Christian healers in Ghana (Kpobi & Swartz, 2018). This suggests that collaboration between formal health services and prayer camps is possible; however, this requires leadership to drive the agenda forward. Further on the feasibility of collaboration between prayer camps and formal mental health service providers, a study which evaluated the effect of giving psychiatric medication to patients restrained by chains in prayer camps reported a significant reduction in symptoms of mood disorders among those in the experimental cluster the ($P = 0.003$, effect size -0.48)(Ofori-Atta et al., 2018). Ofori-Atta et al., (2018) concluded that providing formal psychiatric treatment such as psychotropic medication to patients' resident in prayer camps had a beneficial impact on symptom reduction in the short term but did not significantly reduce the number of days in patients spent in chains (Ofori-Atta et al., 2018).

In the observational study conducted as part of the research for this Thesis, one of the prayer camp leaders indicated that they aim to help people with mental illness by confining them to a place where they are not a danger to themselves and others. However, they seemed unaware that such confining practices as chaining people to trees was a human rights violation. This finding reinforces an earlier study that proposed the need for educational interventions and

working with TFHs, suggesting such a relationship would have significant implications for improving overall healthcare (Bhikha et al., 2015).

5.3 Study population

The prayer camps admit all age groups but mostly those aged 13 years and above. At prayer camp one, the number of patients actively receiving healing on the day of observation was estimated to be approximately 85 (35 males and 50 females), with a corresponding number of family caregivers who accompanied their relatives to the prayer camp to take care of their daily needs. In prayer camp two, there were 66 people (22 males and 44 females) with various health needs on the day of observation. The ages of the people in the prayer camps at the time of observation are shown in Table 11.

Leadership at both prayer camps indicated that mental illness can easily be identified without any professional training. In the camp leaders' opinion, there is no ambiguity in identifying people presenting to the prayer camps with symptoms of mental illness, albeit this does not include being able to diagnose different types of mental illness. However, the researchers could not see all the patients because some were in their rooms and others out of the camp to attend to other personal issues. As the prayer camps are open to public worship, the capacity and membership strength in each camp is estimated to be between 800–1000 worshipers during a regular Sunday gathering. This figure excludes visitors to the facility who come to seek special prayers and divine interventions on other days of the week.

Table 11 Age of people admitted to prayer camps

Age (years)	Prayer camp one	Prayer camp two
13-16	20	20
17-20	15	46
20+	50	66

Patients admitted to the camps are always accompanied by family members who support them while at the camp. The primary carers are not considered to be receiving care; their role is to act as the primary caregivers for their unwell relatives.

It was noted that there were no scholastic activities or formal education provided at the prayer camps for children admitted or accompanied by their relatives to the camps. Where possible, children attend classes at nearby mainstream schools. Both camps are situated in the centre of town and therefore not far from the community schools, although most children admitted to

the camp rarely attend school. There were no leisure or other activities provided to support the children's psychosocial and motor developmental needs

5.3.1 Reimbursement, catering and sleeping conditions

Patients seeking admission into prayer camp usually pay an admission fee of GH₵ 50.00 (USD 9.0). These fees are reviewed periodically based on the economic situation in the country. According to an elder in prayer camp one, the admission fee is to provide meals for patients whose relatives are not there to prepare food for them. The Church elder added that the quality of food prepared at the camp is substandard and insufficient to meet nutritional needs of patients because of the large numbers present. Hence most of the people in the camp prepare their meals to supplement the meals provided by the camps. Patients receive two meals per day.

In prayer camp two according to an elder, patients are not charged admission fees. The elder added that their decision not to charge admission is contrary to reports by sections of the community that they charge patients before healing them as is the practice in some faith-based camps. Prayer camp two only accepted gifts of gratitude from patients who have recovered or healed and returned to the camp to give testimony and thanks for the help given to them.

Prayer camp two only provided food for patients who have been abandoned at the camp by their relatives after initial visits. Since their relatives have absconded, these patients were provided with two meals per day, with the remaining patients' diet being provided by their relatives who were present.

The camps catered for various health conditions, including physical and psychosocial health conditions. In most cases, family members were also resident to support the patients' daily care needs, including preparing additional meals. From anecdotal and observational evidence, it appeared that many of the camp patients suffering from mental illness were malnourished when compared to the non-mental health cohort. This observation was not validated through medical evidence.

The camps provided segregated accommodation on a gender basis except where their families accompanied those being admitted. Patients were provided with a bed although at times demand outstretched availability, with some residents being provided with temporary accommodation in open prayer meeting areas. This was reported as an increasing issue requiring the camp leaders to construct further accommodation. There were no partitions for males and females in the prayer areas used as temporary accommodation at night; this situation was similar in both prayer camps.

5.3.2 Coverage and prayer days

According to the leadership, the prayer camps attracted people seeking spiritual support and healing from across Ghana and transnationally from neighbouring countries such as Togo, Benin and Nigeria. Languages spoken in the camps included Ewe, Ga, Twi, Fante, French and English. People from neighbouring countries attended with their own cultural or spiritual beliefs acceptable at the prayer camps. However, individual religious beliefs outside of the Christian faith are not considered part of the faith-based healing process. There were no reports of tension between non-Christians seeking healing at the camps and the prayer leaders. Language translations were available for all who attended the prayer camps to assist them to assimilate into the cultural milieu of the camps.

According to the spiritual leader of camp two, people from all walks of life consult with the camp leadership group to seek spiritual support and direction. Both prayer camps had received many important visitors locally and internationally since their inception. These visits were related to interests in human rights because of the introduction of the new MHA.

Whilst free to pray at any time, camp residents are expected to attend the mandated prayer days including Wednesday, Thursday, Friday, and Sunday. Of these days, Sunday was the day for the main worship, when members of the public attended the camp's church services to thank God for protection through the previous week. The prayer forms in the camps were similar to the general public and included praise, petition or supplication, intercession, and thanksgiving. Confession of sins committed was also an integral part of the prayer sessions. The camp's collaborative approach to healing took the form of joint responsibility of both God, and the individual. Patients must confess their sins for God to forgive and grant them healing. One of the camp leaders said:

> *"Once a patient is admitted in the camp seeking divine healing, such a patient must necessarily confess previous sins committed either against God or fellow humans to stand any chance of obtaining healing."*
>
> (An elder in prayer camp one)

Participating in prayers and fasting during specific days was compulsory for all admitted into the prayer camps including those seeking treatment for mental illness. Nevertheless, there was no punitive or forced care, as reported by the leaders in both prayer camps. Patients not traditionally of the Christian faith were still included in the prayer sessions because that was the main means of healing at the camps. Agreement by a person, or their carer to come to the prayer camps, was taken to indicate agreement to follow instructions and participate in the healing process. Good health and well-being were the main purposes of the prayers. According

to one of the prayer leaders, fasting (going without food and water) was common, especially on Fridays, for 6 hours. While previously, it was compulsory for patients to fast, according to the camp elders, this was no longer a compulsory residency requirement.

5.3.3 Activities in the prayer camps

The field observations undertaken in the prayer camps showed that patients were engaged in routine daily activities, much as they would have been in their own homes. During the observation period, people in the camps were seen to be sleeping, cleaning, cooking, and praying individually in the prayer rooms within the church premises. There were no social activities outside of prayers and fasting, whereby the camps and community members come together to support healing. Also, there were no leisure or other activities provided in the prayer camps to support the psychosocial and motor developmental needs of those seeking to be healed.

Until recently, most admissions to prayer camp two were persons determined by the camp elder as suffering from a mental health disorder. It was common practice for any resident considered aggressive or at risk to be chained to a tree or caged against their will. However, the GMHA had encouraged prayer camps to collaborate with mainstream mental health services to provide services that do not infringe upon patients' rights in the camp. Accordingly, the church elders stated that personnel from the GMHA had advised that the practice of chaining and caging was inhumane and against the rights of persons who have a mental illness. These practices now contravene the rights of the residents under the MHA. As a result, prayer camp two has moved to work more collaboratively with the GMHA, and the practice of chaining and caging has ceased with many of the residents being discharged to various health facilities on the advice of the GMHA.

5.4 Sources of funding for prayer camps

The prayer camps must be self-reliant as they do not receive external funding from any agency except for some administrative support for the governing council. Patients may be required to pay an admission fee to aid the operations of prayer camp one. These funds were used to cover the cost of accommodation and other social expenses, including food. The camp occasionally received donations from benevolent organisations or individuals.

Similar observations were made at prayer camp two. No external source of funding was available except that of philanthropists and recovered people who return to show appreciation to the leadership for their support. In this prayer camp, two private cars were donated by people who previously benefited from their services to prayer camp leaders to facilitate their movement in the area.

There is a perception in the Ghanaian society that some of the Evangelical Churches that own most of the prayer camps address the material needs and desires of people and, therefore, attract people through promises of material wealth and divine miracles curing ill-health. From experience and observations, most people attending these churches will donate generously to support church activities, which is another source of income to fund Church activities.

5.5 Patient management, treatment outcomes and discharge

Patients' demographic information was recorded on admission to the prayer camps. In prayer camp one, an admission and discharge logbook contained basic demographic characteristics, including contact details of patients and their carers. The information recorded included gender, age, next of kin details, home address, phone numbers and signature or thumbprints of patients and carers.

An elder (leader) in prayer camp one identified successful outcomes of treatment and quality of healing as contributing to the high demand for admission. According to this elder, about 90% of patients are healed and recover completely. The elder also expressed the view that the prayer camp had better treatment outcomes compared to mainstream services. The leaders expressed similar views in prayer camp two. An example was cited of a woman who had reported seeking treatment at a hospital for 17 years without improvement until she attended the prayer camp. According to the prayer leader, this woman was paralysed but could now live independently because of the healing she received from the camp. The researchers could not validate the story as the patient had been discharged from the prayer camp prior to the day on which the observation was conducted. Further studies are needed to validate the report that patients have higher treatment outcomes compared with biomedical mental health services as reported by one of the prayer camp leaders.

The average length of stay in camp one was one month, but exceptions were given to patients with serious mental health problems who were allowed to stay for up to three months depending on the severity of the condition. The camp leaders viewed recovery as a journey over time, but which had an end. Readmission was seen as an unexpected outcome which indicated a failure of spiritual treatment; under such circumstances, the patient was discharged.

Another elder of prayer camp one said prayer is more effective than mainstream health medicine because there are certain sicknesses, "spiritual or non-spiritual" which the hospital cannot successfully treat. He added that diseases with unknown causes, including mental illness, have better recovery rates at the prayer camp than those in the orthodox health facilities. The camp leadership indicated that healing through “flogging, caging and forced

fasting", which had been the practice in some churches, was not an acceptable practice. Instead, it was suggested that "prayer is the key" to managing and curing all kinds of health problems in the camps, a mental health nurse is always called to the prayer camp to manage agitated patients.

In prayer camp two, a logbook was also kept in the camp for recording admission and discharge information of patients. Basic demographic information was usually recorded, such as name, gender, age, relatives and home address. In contrast to camp one, in camp two, a mental health nurse carefully assesses mental health patients before they were discharged from the prayer camp. In addition to the spiritual support provided by the prayer camp, relatives were informed about the patient's recovery, and hence the need for them to be discharged. On the other hand, the abandoned patients who have recovered were repatriated by the camp to their communities provided the patients could describe the location of their communities. In such cases, these abandoned patients who had recovered were usually accompanied by the camp leadership into the community for reintegration into their families. In prayer camp two, the average length of stay was between three and twelve months with occasional and recurrent relapses. Nowadays, patients with mental problems are not forced to join prayer sessions or fast in prayer camp two, and fasting to seek divine healing is now voluntary. It was explained that Prayer camp two had move its thinking positively acknowledging that recovery from mental illness is a journey that might require readmission:

> *"We see recovery as a voyage because there are examples of patients returning to the camp after discharge."*
>
> (An elder of prayer camp two)

In prayer camp two, the elder indicated that treatment relapse could not be attributable to spiritual failure; nevertheless, the camp leaders were concerned about patients whose recovery was slow. For the camp leader, once a recovered patient goes back to the community and refuses to comply with the directive by the camp prophet to live an upright life, the sickness may recur. This is not seen as treatment failure but a consequence of the individual's lifestyle, placing them at variance with God's teachings. This emphasises the idea of collective responsibility whereby both the individual patient and God has to perform their roles to ensure complete healing.

There was an interesting observation in prayer camp one. During the observation, a 33-year-old female presented to the camp with complaints of skin rashes and insomnia, claiming that the treatment she had received at her local hospital had failed to cure the condition. It was

noted that she was initially refused admission at camp one until she bathed. The elder of the camp stated:

> *"You have to go back to the house and bath, then come back to the prayer camp for admission."*
>
> (An elder of prayer camp one)

Although 'spiritual cleansing rituals' are common practice within faith-based organisations in developing countries such as Ghana, at face value, it appeared that the initial refusal to admit the young lady was based on the woman's unkempt presentation. This was purely a matter of hygiene, where patients needed to tidy themselves before admission to the camp. It also appeared that the young lady had no concerns with the request by the elder of the prayer camp to go back and tidy herself before admission could be granted. During a formal interaction with this lady upon her return to the camp, she believed that a faith-based approach would cure the sickness and that her presence in the prayer camp was on a trained health worker's advice. She said:

> *"I had been to several places, including hospitals without cure of my sickness. I was directed to this camp by a health worker in one of the health facilities."*
>
> (A 33-year-old female patient)

5.6 Cultural conceptualisations of attribution of mental illness

There are various ways that patients and prayer camps use religious or spiritual beliefs to find answers for illness or sufferings. One of these is *Punishing God Reappraisal,* whereby the individual interprets the suffering or mental illness as a punishment from God for not living an upright moral life. Another is *Benevolent Religious Reappraisal,* where the individual interprets the suffering as part of God's plan or as a potentially valuable experience to grow spiritually. A third is *Demonic Reappraisal* also known as *Magical model*, a situation where illness or the suffering is attributable to satanic or demonic spirits (Bhikha et al., 2015; Pargament et al., 2005). These explanations were evident in the prayer camps that were observed in this study.

A number of explanatory models of mental health were observed to be driving the care provided in these prayer camps. Explanatory causational beliefs in Ghana commonly include syncretisation of moral, spiritual, magical/traditional, medical, and psychosocial aspects. Most of the time, prayer camps will combine these beliefs to formulate their treatment. Patients may use more than one form of treatment approach at the same time to address their health problems.

5.7 Collaboration with orthodox healthcare

There was evidence of collaboration and to some degree, integration of care, between the prayer camps and local health services. At prayer camp one, the School of Medicine, Nursing and Midwifery at the University of Health and Allied Sciences in Ho facilitated collaboration between the health facilities in the area and the prayer camp. There were periodic health checks when orthodox health workers visited the prayer camp to offer general health screening. Those identified as needing physical healthcare were referred to mainstream health services with the consent of the camp leader.

In prayer camp two, a 10-bed mixed gender unit was constructed by the GMHA for high-risk patients who could not be safely reintegrated into their communities. When the observation was conducted, there were six persons (two males) with mental disorders residing in the 10-bed unit. This was particularly important because some of the people who recovered had not reintegrated into their communities due to widespread stigma and discrimination. Due to recent intervention by the GMHA two patients were discharged from the prayer camp and referred to Ankaful Psychiatric hospital for treatment. Other patients were discharged to their homes following treatment, albeit several returned to the camp due to the stigma and discrimination they experienced on reintegrating into the community. Also, the intervention by the GMHA resulted in fewer patients with mental disorders being admitted into prayer camp two. According to the elder of camp two, aggressive patients were no longer admitted into this camp due to concern about the MHA, which has criminalised the chaining and caging of people living with mental disorders.

The leadership of the prayer camps acknowledged that patients often require physical and spiritual healing and where necessary referred cases, at the patient's expense, to the nearest orthodox health facilities. This seemed to be at odds with the prayer camp leaders' assertion that the prayer camp produced better treatment outcomes than orthodox treatment and that they could deal with all forms of ill-health. Some of the cost involved in such referrals included medication and transportation.

In Ghana, psychotropic medicines are program drugs that are supposed to be provided at no cost to the patient but are often unavailable. Inconsistent supply and lack of psychotropic medicine limit the services provided to patients within the prayer camps (Badu et al., 2018; Oppong et al., 2016a; Roberts et al., 2014a; Walker & Osei, 2017). The NHIS does not cover such medications because they are program drugs, mostly donated by external organisations. Most of the patients in the prayer camps could not afford the cost of treatment in health facilities. On discharge from hospital, patients returned to the prayer camps for follow-up spiritual healing and guidance from the prayer camp leaders. Following the field observation

in the prayer camps, contact was made with the psychiatric nursing team at the regional hospital in Ho and the Ankaful Psychiatric Hospital in Cape Coast which confirmed that since the introduction of the MHA, a more collaborative approach had been established between the prayer camps and public health services.

A Community Psychiatric Nurse in Cape Coast who confirmed having a working relationship with prayer camp two, highlighted the lack of psychotropic medicines as major challenge nationally to further integrating care between the prayer camps and public health services. Hence, he was unable to embark on scheduled visits to the camp. He indicated:

> *"I am not visiting as frequently as expected to the prayer camp because of lack of medication for them [referring to people with mental disorder]. I do not want to visit patients and not be in a position to help them with medication. Psychotropic medication is no longer free as patients are now being asked to buy them, and obviously, these are a group of people that do not have the financial means to procure these medications."*
>
> (Community Psychiatric Nurse)

As noted previously, there were no acts of chaining or caging of patients with mental disorders during the period of observation. According to the camp leaders, aggressive patients are referred to health facilities within the catchment areas for treatment and management. Mental health nurses occasionally visit the camps to administer psychotropic medication to patients. The camps' biggest challenge was the inability to procure psychotropic medications for the patients, which sometimes contributed to relapse.

5.8 Stigma against people with mental disorders

Prayer leaders indicated that stigma and social rejection towards people with mental illness were prevalent even after they had recovered. Patients often remained in the prayer camps beyond their treatment need due to the reluctance of family and community leaders to accept them because of the stigma associated with mental illness. This was confirmed by one of the female patients in prayer camp two, who indicated how she wished to go back to trading but found it difficult due the stigma and discrimination that she experienced:

> *"I lost my capital as a trader. Town folks will not buy my items just because I had a previous mental problem."*
>
> [IDI, A female mental health services user in prayer camp two].

Consequently, this female patient lost the funds donated to her since people will not patronise her business because of her experience as a person with previous mental illness. Moreover, she relapsed due to lack of regular medication. She returned to the prayer camp, and at the

time of the observation, this service user was not on any psychotropic medication due to lack of supply.

5.9 Chapter summary

Prayer camps have a well-established history in Ghana, with both positive and negative implications. On the positive side, these camps are located within communities, are readily accessible to people with mental illness, with some having established collaborative links with formal health services; this is often not the case with conventional health facilities. A major concern is a history of systematic human rights violations, including the widespread use of restrictive practices such as chaining residents with severe forms of mental illness. The present burden of mental health problems throughout Ghana and the insufficient availability of orthodox mental health services calls for consideration of novel approaches to increasing access to mental healthcare in a low resource environment. Formalising collaborative arrangements between prayer camps and orthodox health services to support and treat people with mental health problems could provide opportunities to use existing resources better to improve mental health outcomes.

Given the acceptability and widespread availability of prayer camps in Ghana, there is a need for both orthodox and non-orthodox practitioners, for example, TFHs, to collaborate and work together to improve mental healthcare holistically. Ultimately, there is a greater need for regulatory agents such as the GMHA to perform legally mandated supervision to ensure that human rights are respected in all mental health services and facilities, especially in the prayer camps that can be found across the length and breadth of the country. This would require that regulatory processes be developed to formalise prayer camp healers into the mental health workforce.

Chapter 6 presents the stakeholder's views on the progress of implementation of the MHA since its introduction in 2012

Chapter 6 Progress of implementing the MHA

6.1 Introduction

This chapter presents the findings from in-depth interviews and focus group discussions with stakeholders about the progress achieved in implementing the MHA. The stakeholders who participated in the research are presented in Table 12. The chapter begins with an overview of progress in implementing the MHA, as pointed out by the research participants. This is followed by a discussion of access and affordable mental healthcare, integrating mental health services into primary healthcare, and reducing stigma and discrimination against people with mental ill-health. Publicity, awareness and knowledge of the MHA among the public and factors retarding implementation are also discussed. Quotations from the interview transcripts are provided in support of the views expressed by the research participants. The chapter concludes with a summary of achievements made in mental healthcare since the MHA's introduction and recommendations regarding further work to be undertaken to speed its implementation throughout Ghana.

6.2 Participants

Fifty key stakeholders participated in the research interviews, comprising 6 females and 31 males for the IDIs, 9 females, and 4 males for the FGDs.

Table 12 List of study participants and data collection approach

Stakeholder	**Method**	**Interviews completed**
Ministry of Local Government	IDI	2
Ghana Health Service	IDI	2
National Health Insurance Scheme	IDI	2
Social Welfare and Community Development	IDI	1
Attorney Gen & Ministry of Justice	IDI	1
Commission for Human Rights & Administrative Justice	IDI	1
Ghana Police Service	IDI	1
Member of Parliament of Ghana	IDI	1
Ministry of Finance	IDI	1
Ghana Mental Health Authority	IDI	1
Regional Mental Health Coordinators (RMHC)	IDI	10
Psychiatrists	IDI	2
Psychologist	IDI	1
Clinical Psychiatric Officer	IDI	1
Community Mental Health Officer	IDI	1
Non-Government Organisations	IDI	3
Traditional and Faith-based Healers	IDI	3
Community opinion leaders	IDI	1
Mental health service user	IDI	1
Mental health service users/carers	FGD	1
Mental Health Officers / Psychiatric Nurses	FGD	1
Total		**38**

6.3 Progress of overall implementation of the MHA

Participants discussed the progress of implementing the MHA and achievements in mental healthcare since its enactment in 2012 during the IDIs and FGDs. Participants considered that some reforms had been accomplished, which were attributable to the introduction of the MHA. As a stakeholder group, mental health service providers discussed achievements in mental healthcare facilitated by the introduction of the MHA. An RMHC indicated that despite the challenges faced in implementing the MHA to improve mental healthcare delivery, some progress had been made, including the establishment of the GMHA to oversee the implementation of the MHA, and the appointment of RMHCs to coordinate mental healthcare in their respective regions:

> *"The MHA has been a good start despite the numerous challenges, as you may be aware that the Legislative Instrument which is supposed to give meaning to the law, is supposed to operationalise the law, is yet to be passed. Despite that, we have made some significant strides, such as establishing the GMHA and the appointment of the RMHCs."*
>
> (IDI_#07, RMHC)

The establishment of the GMHA, the appointment, and installation of both the RMHCs and the regional mental health sub-committees, were considered major achievements by most participants:

> *"I can say that the GMHA has been established, RMHCs have been appointed, and regional mental health sub-committees have been inaugurated. These things have been done because they were provided for in the law and have been done. "*
>
> (IDI_#07, RMHC)

> *"Comparing the MHA's onset with what we had previously, I will say there has been some progress though not much. Since the passage of the Act in 2012, we have had appointments of new staff; I am an example, appointment of RMHCs, and regional mental health sub-committees in all the regions to coordinate mental healthcare. There are various training and sensitisation programs about the Act, which I see as an improvement from previous expectations."*
>
> (IDI_#04, RMHC)

Further to this, an RMHC identified that there had been an increased emphasis on education and training for stakeholders at the district level about the legislative requirements of the MHA:

> *"We have trained key stakeholders about the MHA, the police and prison officers, traditional and faith-based healers, and general health workers. We have sensitised these corporate*

> *organisations at the various regional and district levels; we have also empowered the acting district coordinators in the various districts who have also started sensitising relevant stakeholders about the MHA at their districts."*

(IDI_#10, RMHC)

A psychiatrist acknowledged that the introduction of the MHA increased the protection of individual human rights by requiring assessment by two independent psychiatrists before admission to a psychiatric facility. This statutory requirement has been introduced partly to prevent past behaviour where families indiscriminately abandoned family members in mental health institutions and to ensure that only people requiring mental healthcare are admitted to health facilities:

> *"We expect the certificate of urgency, which ensures that patients admitted against their will actually need admission. In the past, based on a relative story, just with one psychiatrist assessing, they will just admit the patient involuntarily, but not so anymore because of the MHA. At least two independent psychiatrists will assess, and there will be a confirmation that the person needs admission."*

(IDI_#01, Senior Psychiatrist)

Another RMHC stated that past practices, such as administering treatment to patients without their formal consent or not explaining the effects of treatment, were no longer allowed under the new law:

> *"For example, in the Northern region, some of the ongoing practices were against the fundamental rights of people living with mental illness. Patients are sometimes forced to undergo treatment without their consent or the health worker explaining the treatment consequences to them."*

(IDI_#06, RMHC)

The problematic interface between therapy and abuse within faith-based healing centres was discussed by an RMHC acknowledging the need for TFHs to understand their duty of care under the Act:

> *"Again, with regards to TFHs, some of them use to put people with mental illness in shackles chains, so we explained some of these things to them, and we make them understand it is against the fundamental rights of patients. The introduction of the MHA facilitated these sensitisation programs."*

(IDI_#05, RMHC)

Another area of progress made towards implementing the MHA is the training and sensitisation of law enforcement agencies about the provisions of the MHA and the need for these agencies

to protect the rights of people with mental illness. Implementing the MHA is also considered to have encouraged some people with mental illness to become more assertive and demand their rights. An RMHC noted the juxtaposition between the increased human rights awareness of people living with mental illness and the need for Government agencies, including the police and judiciary, to acknowledge their responsibilities under the Act:

> *"Before the introduction of the MHA, when people with mental illness commit criminal acts, they found it difficult to voice their issues, but now we have sensitised the judiciary, the police and the prison service officers to understand that mental illness can happen to anybody and when it happens there are laws that govern how people with mental illness should be handled. Therefore, people have realised that those with psychological and cognitive disorders have a say within the laws, which is a terrific turn for the GMHA."*

(IDI_#03, RMHC)

An RMHC reported that there had been an affable collaboration between the GMHA and key Government agencies to ensure the protection of the rights of people living with mental illness:

> *"We are also collaborating with the police service, prison service, and social welfare department to address people with mental illness issues in the region."*

(IDI_#01, RMHC)

Implementation of the MHA has also contributed to changing expectations regarding the training and sensitisation of TFHs to avoid inhumane treatment of people living with mental illness, a major policy aim. A psychiatrist discussing changes that she had witnessed since the introduction of the MHA indicated that the inhumane practices previously associated with traditional and faith-based healing centres were slowly reducing as the centre leaders gained further insight into their responsibilities under the Act:

> *"TFHs have also been educated to minimise or stop drastically the inhumane actions or maltreatment of people with mental ill-health, which was one of the MHA's primary focus. There has been some improvement in that aspect, as it is now illegal to chain or shackle patients."*

(IDI_#01, Psychiatrist)

In 2018, the GMHA developed a policy guideline to be used by TFHs when managing people with mental illness at faith-based healing centres (Ghana Mental Health Authority, 2018). This was considered a significant achievement of the MHA. However, it appears that this policy document has so far achieved limited penetration amongst key policymakers and those responsible for implementation. For instance, a representative of the National Health Insurance

Scheme (NHIS) was unaware of the existence of this guideline, which was introduced in 2018 to prevent rights abuse by TFHs:

> *"We need to develop guidelines to ensure that human rights abuse is minimised in unorthodox treatment facilities, such as the traditional and faith-based healing centres."*
>
> (IDI, National Health Insurance Authority)

6.4 Access to affordable mental health services

Decentralisation of mental health services to primary healthcare remains a priority. The theory behind decentralisation contains several conceptual elements, including improved governance, increased service delivery efficiency, and devolved decision-making, emphasising partnerships at a local level (Patrinos et al., 2009). Decentralisation is a major construct of the MHA, aligning mental health with public health and, in so doing, reducing congestion at the three major psychiatric hospitals. An RMHC indicated that resources remained inadequate to ensure access to mental healthcare for patients:

> *"Now we are focusing on the decentralisation of mental healthcare. Attention is focused on the primary healthcare level, where the bulk of the people are; we should empower the sub-districts to treat mental disorders instead of referring them to the bigger psychiatric hospitals for treatment. This is a work in progress as resources still limit us."*
>
> (IDI_#03, RMHC)

Key aspects and provisions of the MHA include procedures for voluntary and involuntary admission, treatment and establishment of mental health tribunals. Concerns were raised that voluntary treatment for mental illness was not being put into effect due to the lack of tribunals to ensure observance of due process. Some patients were still being subjected to treatment without consent. However, some participants agreed there is now some clarity regarding processes for managing patients who were reluctant to undergo treatment. Nonetheless, these processes were not yet adequately operationalised. An RMHC described the procedures currently in place for voluntary and involuntary treatment of people with mental illness:

> *"The MHA prescribes procedures for voluntary and involuntary admissions. We encourage only voluntary admission at the community level, and we propose that involuntary admissions go through the court system before admission is granted."*
>
> (IDI_#09, RMHC)

Further to this, participants from different stakeholder groups acknowledged that the structure and provisions required to operationalise voluntary and involuntary treatment were not fully functional. This was attributed to the failure of Government to establish the mental health

tribunals to ensure proper procedures were being followed during the admission process. Notwithstanding, the MHA did help to clarify treatment procedures and has brought clarity to clinical practice. A senior psychiatrist expressed concern that some patients were still being forced to undergo treatment without consent:

> *"We are supposed to have national and regional mental health tribunals that should be able to determine whether a person who was admitted under involuntary procedure should continue on admission or not. This procedure is presently discretionary because the tribunals have not been established to perform this critical duty under the MHA. So, we are not fully operationalising the Act. However, I can also say that indeed the MHA had brought some clarity to the procedures for voluntary and involuntary admission because in times past, even when people were brought into the facility screaming, crying, and kicking things, they are classified as voluntary simply because they were not ordered to be brought in by the court."*

(IDI_#02, Psychiatrist)

Another community psychiatric nurse considered that family consent for treating an unwell relative should be considered voluntary treatment, a position that is contrary to what is required under the MHA. This lack of understanding of the legal definition of 'voluntary' will likely have direct implications for clinical practice. Lack of understanding of the meaning of 'voluntary' under the MHA remains widespread among staff; none of the other community psychiatric nurses present at the focus group raised concerns about voluntary treatment being understood in this way:

> *"I will say that treatment for mental illness is voluntary. We cannot say the patient himself or herself should consent to treatment. However, the family member will voluntarily say, we want our relative to be treated, and the family will take their relative to the psychiatric facility for treatment."*

(FGD_#02, Community Psychiatric Nurse)

A clinical psychologist discussing the need for regional mental health tribunals and human rights-based institutions asserted that most people living with mental ill-health are generally unaware of where to report and seek redress to abuse of their rights. This, in part, is due to the unavailability of institutions to safeguard human rights and patients' lack of awareness of their rights:

> *"Most people do not even realise when their rights are being abused, and those who get to know that their rights have been abused do not know where to report. The district and regional mental health tribunals that are supposed to be established to address human rights concerns of people living with mental illness have not been institutionalised. We have been advising patients whose rights have been abused to seek redress from the Commission for Human Rights and Administrative Justice."*

(IDI, Clinical Psychologists)

The majority of mental health service provider participants believed the introduction of the MHA had facilitated increased access to mental healthcare due to the expansion of primary mental health services, including staff and community mental health services across the country. However, many of the participants agreed that the increase in access to mental health services did not directly result in affordability because of the inconsistent supply of psychotropic medication in the health facilities.

An RMHC outlined achievements resulting from the introduction of the MHA. This participant asserted that mental health staffing had increased; for instance, the appointment of mental health coordinators had resulted in increased services being provided across the country. Mental health services were now being provided at all regional and district hospitals, including some health centres. Access to mental health information had also improved as attention had now shifted from institutional to community-based care:

> *"The RMHCs have been installed following the introduction of the MHA, and there is much information about mental health now. We are now focusing more on community-based mental healthcare with the posting of staff into the various districts, which was not the case in the past. The aim is to ensure the integration of mental healthcare in primary care. Therefore, the MHA has brought care to people's doorstep because some people now receive healthcare within their communities."*
>
> (IDI_#10, RMHC)

Similarly, a senior psychiatrist acknowledged that the movement from the old paternalistic model of institutional-based care to a more integrated and community-based approach involving the establishment of psychiatric units in some district hospitals and health centres had improved access:

> *"There has been the setup of psychiatric services in several district hospitals, which is a plus, and that was one of the things the MHA sought to do to promote mental health services in the district or the community level. A lot of such facilities have been established in the district and the communities. People are becoming aware of mental health conditions in general, helping them seek help earlier than they would have done in the past."*
>
> (IDI_#01, Psychiatrist)

Further to this, another RMHC considered the introduction of the MHA had brought an increase in the number of mental health services cohabitating with primary care services. The mental health units include both dedicated structures and temporal locations arranged for mental health service provision. According to this participant, while access to mental healthcare had increased, affordability remained a barrier because of the spasmodic availability of medication and associated out-of-pocket costs to the individual:

> *"From 2015 to 2018, per my records, we have moved from 25 to 98 mental health units in my region, so I can say that there is increased access to mental health services, reaching out to the broader community. However, we do not have the required resources, including medication, to render effective services. So, patients are often only seen, assessed, and asked to buy the medication themselves. Most patients cannot afford the cost of medication, and so it is affecting access."*
>
> (IDI_#09, RMHC)

According to some participants, the introduction of paraprofessionals such as medical assistants to provide psychiatric assessments has allowed for the rapid expansion of the mental health workforce:

> *"We have built capacities of medical assistants who hitherto were not attending to people with psychiatric symptoms in the various hospitals, thereby bridging the geographical access gap. People will no longer travel to the bigger cities to access mental health services. Medical Assistants in the region have been trained in basic psychiatry to assess and make referrals where necessary. So, we have been able to increase access to mental health services."*
>
> (IDI_#07, RMHC)

> *"In this region, all public hospitals now provide basic mental health service; all polyclinics have mental health facilities, and many health centres also provide mental health services. In the past, not every District in the region was providing mental healthcare. However, with the MHA passage, regional RMHCs have been appointed who are ensuring that mental health services are provided in all the health facilities."*
>
> (IDI_#05, RMHC)

A psychiatrist remained optimistic that further progress towards implementing the MHA would be achieved through decentralisation and expansion of the mental health workforce because of the inclusion of paraprofessional Medical Assistants:

> *"With community-based care, it is now easier to access mental health services. In times past, if a patient needed to access mental healthcare, he or she needed to be in one of two regions, that is either the Greater Accra or Central regions, but with the introduction of the MHA and emphasising community-based care, at least mental health services are now closer to people regardless of location. Trained mental health personnel with basic knowledge are available to provide minimum mental healthcare."*
>
> (IDI_#02, Psychiatrist)

The introduction of the MHA had facilitated the expansion of mental health services in the regions as mental health personnel were located in all primary health facilities, resulting in a level of operational integration with primary healthcare services. It was generally agreed by a

number of the participants that access to mental healthcare had improved across the country due to the increased deployment of mental health workers in Districts and sub-districts. However, affordable mental healthcare remained elusive since mental health service users were still asked to pay for services, including medication. These participants asserted that central Government was not providing the required resources, including essential psychotropic medicines, which are supposed to be supplied free of charge to patients:

> *"Access to mental health services across Ghana has improved due to the introduction of the MHA. The number of mental health workers in my region has increased over the years. At least we have a mental health worker positioned in each of the sub-districts in the region. However, I do not think it has improved in terms of affordability because people still pay out of pocket for medications, even in the psychiatry hospitals. It is not free as stated, which is against the MHA."*
>
> (IDI_#08, RMHC)

> *"Mental healthcare in the regions has improved. Previously, there were only five facilities in my region that provided mental health services, but now all twenty-five health facilities provide mental health services. We have ensured that mental health nurses are distributed to all the hospitals in the region, and people are becoming aware of mental health issues. As for affordable mental healthcare, we still have a long way to go because mental health service users still have to pay for their medication because we do not have enough supplies."*
>
> (IDI_#01, RMHC)

Another RMHC suggested that mental healthcare should be consolidated under the NHIS in order to improve access to affordable mental healthcare:

> *"The NHIS does not cover mental healthcare, and therefore, I would argue for the cost of mental health services to also be covered by the health insurance scheme to improve mental health affordability."*
>
> (IDI_#04, RMHC)

Whilst a number of previous comments referred to improvements in resourcing at the national and regional level, decentralisation and concomitant resourcing, according to a clinical psychologist, does not appear to have been systematically achieved nationally as only part of the staffing solution has been implemented:

> *"Not really; we are still using the old structures. Apart from installing the RMHCs, the District mental health coordinators have still not been appointed. This delay in appointing these critical staff is due to a lack of funding."*
>
> (IDI, Clinical Psychologist)

Participants representing NGOs stressed that even though the implementation of the statutory provisions has been slow, there have been some mental healthcare achievements. A representative of an NGO indicated that the MHA has the potential of overhauling mental health services despite the sluggish implementation as a result of inadequate resources, which seemed to be the case for other policies regarding their implementation in Ghana:

> *"To a large extent, the MHA is a step in the right direction because it will overhaul mental healthcare in the long run, as classified by the World Health Organisation. It is only that the implementation process has stagnated due to insufficient resourcing. Most of the time, we have fantastic laws, but implementation becomes a problem in Ghana."*
>
> (IDI_#02, NGO)

Similarly, another NGO participant stated that the introduction of the MHA had brought about increased investment in mental health from both central Government and the NGO sector. This increased investment resulted in an expansion in mental health services across Ghana. According to this participant, some regional and District health service directors have started ensuring that mental health services are provided in health facilities under their supervision. This participant further noted that the increased investment in mental health is still disproportionate to what is needed to ensure full implementation of the MHA:

> *"Largely, there has been some investment in mental healthcare from central Government and NGOs. Unfortunately, the amount of investment required has been inadequate. Some NGOs are willing to put in further investment to address Ghana's mental health issues because they believe the MHA is a progressive step forward. In the past, some Districts and regional directors of health services lacked motivation to establish mental health units within their health facilities, but they have realised that it is imperative to establish these units with the advent of the MHA."*
>
> (IDI_#01, NGO)

Notwithstanding the establishment of the GMHA and Board of Governors, which were described as a major achievement as a result of the MHA introduction, two NGO participants asserted that more still needs to be done to protect the human rights of people living with mental illness:

> *"Since the introduction of the MHA in 2012, we have seen the establishment of the GMHA, as a separate department under the Ministry of Health with responsibility for mental health. There is a Mental Health Board that is overseeing the activities of the GMHA and a secretariat that is working to ensure that mental health policies and standards are up to date. Also, there is a new sense of direction amongst stakeholders towards mental health, human rights and disability issues."*

(IDI_#01, NGO)

"Since the MHA was enacted in 2012, I can say that some level of implementation has been done. One of the key things that have been established is the GMHA. There is a Mental Health Board in place; regional mental health coordinators are in place for all ten regions. However, there is further work to be completed."

(IDI_#03, NGO)

A number of policymakers also discussed the progress of implementation and subsequent achievement of the MHA since its introduction. According to these participants, achievements include establishment of new structures and staff appointments for mental healthcare across the country. A senior mental health administrator listed several achievements resulting from the introduction of the MHA, albeit they also asserted that a lot more needed to be done to improve overall mental healthcare. Among the MHA's achievements stated was the appointment of RMHCs, the establishment of the GMHA and its governing board, drafting and pursuing the ratification of a mental health levy to fund mental healthcare; and the development of guidelines to regulate activities of TFHs:

"We have established the GMHA as an autonomous agency under the Ministry of Health to direct the affairs of mental healthcare in Ghana. We have a Mental Health Board overseeing governance of the GMHA; we have been able to establish a legislative instrument that is currently before Parliament for approval to provide mental healthcare funding. We have appointed RMHCs together with regional mental health sub-committees to coordinate mental healthcare in the regions. There is formal recognition of TFHs as frontline informal community mental health workers, and protocols and guidelines developed to regulate their activities, which will dramatically reduce human rights abuses such as putting patients in chains, shackles, and seclusion at faith-based healing centres. So, yes, we have made major strides, but a lot more remains to be done in the area of funding mental healthcare."

(IDI, Senior Mental Health Administrator)

According to a senior mental health administrator, and in contrast to many other participants, the administrator claimed that the MHA's introduction had indirectly resulted in affordable community-based mental healthcare. Community-based mental healthcare was described as all care outside of the three state psychiatric hospitals. People with mental illness do not need to travel long distances to Accra, Ankaful, and Pantang to seek psychiatric care:

"We have embarked on community-based care, one of the main areas of focus for the GMHA, and this had resulted in the establishment of outlets within health facilities for the provision of mental health services. This reduces the cost of mental healthcare as services are now closer to people. Furthermore, we have seen a drop in outpatient attendance at the main psychiatric hospitals due to increased community-based care."

(IDI, Senior Mental Health Administrator)

A sitting member of Parliament acknowledged the importance of the MHA asserting the need for further community advocacy for investment in mental health with Government:

> *"We have achieved something; at least we have had the bill passed into law and signed. We are now working towards passing the legislative instrument, which has been drafted and in Parliament for review. We need more commitment by Government to mental health, and that can be achieved through stakeholder advocacy."*
>
> (IDI_#02, Member of Parliament, Ghana)

A social welfare and community participant expressed mixed views about the MHA's impact since its introduction. The participant indicated more awareness is needed for people on how to access the annual District Assembly Common Fund allocated to support people living with disabilities:

> *"I must say that because of this Act, we have realised that mental illness can be disabling and therefore we have to help them to access the disability fund. However, some of these people do not know about this facility and are not accessing it. So, we need to create this awareness for those living with mental illness to access the fund."*
>
> (IDI, Social Welfare, and Community Development)

Two psychiatrists were upbeat in discussing the influence of the introduction of the MHA on the opportunity for clinical staff to further their interest and training in mental health:

> *"There had been some training for more psychiatric service providers facilitated by the MHA. The Ghana College of Physicians and Surgeons classified psychiatry as a deprived speciality. It gave some incentives for clinicians who have completed their housemanship job not to do the statutory two-year medical officer superintendent in the districts before they can start practising. Medical Officers are now able to start residency as early as possible, which attracted people into psychiatry. So, the College is training more psychiatrists to support mental health delivery."*
>
> (IDI_#01, Psychiatrist)

> *"Efforts have also been made to increase physicians' intake into the Faculty of Psychiatry under the Ghana College of Physicians and Surgeons to train more psychiatrists."*
>
> (IDI_#02, Psychiatrist)

Confirming the point made by participant IDI_#01, Psychiatrist above, a policymaker from the NHIS expressed a similar view that the MHA's introduction has motivated people to want to train as mental health professionals:

"Yes, because of the introduction of this MHA and the advocacy programs, people are now interested in training to become mental health professionals; I think the MHA introduction is a great boost for this interest."

(IDI, Municipal Health Insurance Authority)

6.5 Progress towards integration of mental health services

The anticipated advantages of integrating mental health in primary healthcare include reduced stigma, improved access to care, reduced chronicity and improved social integration (Crowley & Kirschner, 2015; Kigozi & Ssebunnya, 2009; Lund et al., 2016). This is particularly important in low-income countries because the lack of mental healthcare resources makes it especially important that healthcare providers collaborate effectively to maximise efforts (Lund et al., 2016). Mental health providers who participated in this study discussed the role played by the MHA legislation towards integrating mental health into primary healthcare. Two RMHCs reported that the GMHA was currently collaborating with the GHS to ensure the effective integration of mental health services in primary healthcare:

"The introduction of the MHA is integrating mental health into primary healthcare. We do not have the staff and resources to deliver mental health services alone, so we are using existing structures that we have, working closely with the GHS to provide mental health services within the existing primary healthcare facilities."

(IDI_#04, RMHC)

"The MHA aims to integrate mental health in primary healthcare, which is slowly being achieved.; We are looking at how mental healthcare would be accessible at all levels of care from the community to the sub-district, District, Regional and National levels. Despite the numerous challenges with implementation, the introduction of the MHA has been a good start."

(IDI_#07, RMHC)

In acknowledging that changing the model of largely institutionally based mental healthcare to an integrated community care approach will be challenging in terms of both funding and human resource shortages, two RMHCs pointed to the need for a gradual process of service integration:

"I would say mental health has not been adequately integrated into primary healthcare, not fully yet; I think it is still in the process of integration. There are few challenges, including lack of funding and cooperation from some staff of the GHS. While some GHS staff are interested in working together, others are unwilling to share their resources, such as a vehicle with mental health staff for community outreach programs. Nevertheless, I am sure that we will get there."

(IDI_#10, RMHC)

> *"There are many barriers facing the full implementation of the MHA. Financing is one challenge, prioritisation of mental health is another, but at the regional level, we are doing our best to ensure that this Act is implemented in the area of integrating mental health in primary healthcare; thus, ensuring equitable distribution of human resources to all parts of the region."*
>
> (IDI_#05_RMHC)

A community mental health officer claimed that a lack of cooperation from senior management was a barrier to collaboration and mental health integration in primary healthcare. This participant asserted that some of the GHS Directors were not interested in mental health, either due to ignorance or a general lack of importance attached to mental health in Ghana:

> *"Mental health has not been integrated very well in primary healthcare. In some Districts or municipalities, the directors of health services are not interested in mental health. Some of these directors do not understand the concept of mental health or may have realised that the nation itself does not pay attention to mental health. Whether their dislike of mental health is due to stigma, lack of resources, or they do not understand the concept, it is frustrating and impeding the MHA implementation."*
>
> (IDI, Community Mental Health Officer)

A senior psychiatrist expressed the view that there has been significant progress in integrating mental health in primary care. According to this participant, psychiatric admission beds had been allocated in some regional health facilities. Further to this, he stated that there had been increased mental health education and training provided to generalist health staff in the regional hospitals:

> *"Although we have come a long way with integration, we are not there yet. t There have been some positive gains in reducing the gap by establishing mental health units throughout the length and breadth of the country and having it as a policy to have beds or units for persons with mental illness to access care in general health facilities. Regarding the insufficient human resources for mental health, there is also effort to build generalist nurse and middle-level clinician capacity to bridge the mental health workforce gap."*
>
> (IDI_#02, Psychiatrist)

Some of the achievements of the MHA include the formation of mental health units in various hospitals to provide services for people with mental illness. People with mental illness are now more easily identified and treated at the health facilities. This partial integration of mental healthcare according to a senior policymaker is an outstanding achievement of the MHA:

> *"Currently, the ability to identify people with mental illness and provide the services at a unique area within the hospital premises is one outstanding achievement of the MHA. Before then,*

no one cares about people with mental illness on our streets. So, having these units deal with mental and psychosocial issues is a great improvement since establishing the Act."

(IDI, Municipal Health Insurances Authority)

6.6 Discrimination and stigma reduction

Mental illness is associated with discrimination and stigma across the globe (Ae-Ngibise et al., 2015; Awenva et al., 2010; Badu et al., 2018; Walker & Osei, 2017; Whiteford et al., 2013). While some participants considered the introduction of the MHA to have had a significant role in stigma reduction, other participants disagreed, arguing that resources were insufficient to address stigma and discrimination associated with mental illness among the population. An RMHC suggested there had been a re-alignment of practice in some generalist facilities, with patients accessing psychiatric services following the same access pathways as non-psychiatric patients:

"We are trying to ensure that stigma is reduced through the integration of mental health in primary healthcare. Before the introduction of the MHA, we kept folders of people with mental illness at the mental health unit so that when they come to the hospital, these patients are directed to that unit for assessment. This practice was seen as stigmatising. To date there has been some integration of mental health in primary healthcare, and we are advocating and insisting that people with mental illness also take their folders to the general open patient department (OPD). They should be seen by a medical officer or a physician assistant, and if they need a referral, they are referred to the psychiatric unit for further assessment. This new arrangement, which is being implemented by some health facilities, is aimed at reducing stigma."

(IDI_#06, RMHC)

Similarly, another RMHC stated that stigma and discrimination had declined due to people now talking more openly about their mental health. Nonetheless, much remained to be done to further reduce stigma associated with mental illness:

"We know that various factors account for stigma and discrimination against people with mental disorders. Yes, there is a myth and various misconceptions about the causes of mental illness and all that, we have various cultural factors playing a huge role in stigma perpetuation. I can say that stigma has reduced to some extent due to the MHA activities, to the point that some people now can talk freely about their mental health issues; people now know they have to seek help with certain symptoms. However, there is still some form of stigma attributed to the kind of strong cultural beliefs about mental illness."

(IDI_#04, RMHC)

In contrast, several participants asserted that in their experience, there had been a minimal reduction in stigma; they felt there was a need for increased resources to improve mental health literacy among the general public:

> *"There has been some slight reduction of stigma with the little expansion of mental health services across Ghana. It takes a long time to change people's attitude and practices, so we have to keep reinforcing the need to eliminate stigma and discrimination against people with mental illness. We are doing our best as a team, but we do not have the logistics to get into most communities to sensitise the people."*
>
> (IDI, Municipal Director of Health Services)

Another RMHC agreed with other colleagues that there was a need to integrate mental health into primary health to further assist in stigma reduction:

> *"Stigma reduction will take a while, but when mental health services are absorbed into the primary healthcare services, when the health sector itself is not discriminating or stigmatising mental health services, I think we will go a long way to destigmatise mental illness. So, stigma is reducing due to the MHA but not at the level we all expect."*
>
> (IDI_#02, RMHC)

The media's increased awareness about mental health was thought to have contributed to reducing stigma and discrimination against people with mental ill-health. An RMHC suggested some media organisations had previously used derogatory terms when describing people living with mental illness; this was gradually changing with greater attention being given to mental health services due to the influence of the MHA:

> *"Oh yes, I can also say that stigma has reduced to a large extent because of the MHA, which is ensuring that mental health services are provided in most health facilities. We have educated some of the stakeholders about the MHA, even TFH have been educated. Some radio stations used to refer to people with mental illness as "ABODAMFO" [Mad people], but it is a little better now with the ongoing education, there is some respect for mental health in the region. So, I can say that name-calling has also gone down; stigma is still there, but it is better than before."*
>
> (IDI_#04, RMHC)

Two senior psychiatrists also discussed how the introduction of the MHA and establishment of the GMHA had helped in stigma reduction, suggesting that this had come about due to moving mental health services into the community, working with TFHs leaders to help them understand their obligations under the Act, and through increasing mental health training to generalist health workers.

> *"There has been stigma reduction. Many patients in the prayer camps have been let free; they have gotten the right treatment, have been reunited with their families, have been sent back and incorporated in the community, and are now responsible to their communities. So, that is one of the areas that has helped in reducing stigma. There has also been an opportunity for*

more young people to go into residency training which has also reduced stigma among health professionals. People with mental illness do not have to walk only to Accra or Ankaful or Pantang psychiatric hospitals, which are stand-alone facilities; rather, they can access mental healthcare right in their communities, which has helped to reduce stigma. We still have a long way to go, but then, stigma has reduced to some extent."

(IDI_#01, Psychiatrist)

"Stigma has reduced to some level because of community-based care for persons with mental illness, which is a major aim of the MHA. We are also ensuring that TFH or informal service providers are also rolled in and sensitise to ensure that the rights of persons with mental illness are not abused."

(IDI_#02, Psychiatrist)

Policymaker and NGO participants also discussed the impact of the MHA on stigma reduction. It was suggested that while there had been a stigma reduction, this was below what had been expected. These participants called for greater resource allocation by central Government to enable widespread public education addressing stigma against people living with mental ill-health. In discussing stigma reduction, a senior mental health administrator felt media reporting had improved since the introduction of the MHA:

"Stigma has reduced but not significantly to the point that we want. For instance, before the introduction of the MHA, if you had held this interview in-person at the psychiatric hospital, and a colleague of yours saw you coming from the psychiatric hospital, the question he would have asked you was, why do you have a psychiatric problem? But now, any such person or in most cases, people who saw you coming out of the psychiatric hospital will ask, did you have a program at the hospital? That is a lot of achievement. Again, now the media houses are calling us periodically to find out whether there are connections between certain crimes committed in the community and mental illness; this is encouraging because, in the past, they would have simply concluded that this is a bad person, criminal, or a demon-infested person. But now, some journalists will link it first to a psychiatric problem and call to find out. We think that stigma has reduced, but we need to do more to reduce it further."

(IDI, Senior Mental Health Administrator)

A similar view was expressed by an NGO participant, who suggested stigma had reduced as the implementation of the MHA increased awareness of mental health. This participant further commented that stigma reduction would take time due to the entwined nature of causation of mental illness and traditional animistic cultural beliefs of many Ghanaians:

"Yes, stigma has reduced because people are beginning to talk about it and to let people understand that those who had experienced mental illness do not have to be discriminated. But you and I appreciate that stigma against mental illness has been a long-standing socio-cultural phenomenon that cannot be eliminated within a few years of the MHA existence. So,

> *there is still a lot of discrimination ongoing, but it is also true that the MHA has helped to increase awareness and to encourage people rather to accept and respect people with mental illness than abuse or discriminate against them."*
>
> (IDI_#01, NGO)

A community opinion leader acknowledged that since the introduction of the MHA and subsequent integration of mental health services into primary health, community mental healthcare has increasingly become part of public discourse on health:

> *"There is a generation of this action around mental health; in the past, it was a 'no go' area that people would not like to even speak about it, but for now, it is generating a lot of public interest. In that instance, I will say that this indicates that there is some reduction in stigma and discrimination. It makes me understand that people are now mainstreaming mental health to the public discussions and no longer limited to other typical conditions like malaria, tuberculosis or communicable diseases."*
>
> (IDI_#03, NGO)

Similarly, a Municipal Director of health services observed that stigma has declined following the introduction of the MHA; however, increased resources are needed for public education if there is to be further reduction:

> *"Stigma is reducing gradually, but we have still not reached the level where it is okay, so we need logistics to push further with sustained public education."*
>
> (IDI, Municipal Health Insurance Authority)

At the same time, other study participants thought the introduction of the MHA had so far had little impact on reducing stigma. This was considered to be due to low mental health literacy among the population and a lack of resources for public education to improve literacy:

> *"No, stigma has not been diluted yet because of the lack of resources to combat it. Mental illness is still highly stigmatised, especially in the rural communities."*
>
> (FGD_#01, Community Psychiatric Nurse)

> *"Well, not yet. We have not yet realised any significant reduction in stigma. Through our experiences, I think we are still where we were when it comes to stigma reduction. Education about mental illness is still low, and we need to sensitise more people to understand."*
>
> (IDI, Clinical Psychologist)

A community mental health officer stated that stigma had not been reduced due to a lack of resources addressing this issue. This participant stressed the need for more resources to be

allocated in order to address stigma and reduce ingrained cultural myths concerning mental illness:

> *"Stigma has not been reduced. Behaviour is something that takes a long time to change. We do not have the resources to reach out to people to communicate with them; you only have the chance to communicate with the few that you have been meeting in the facility. Even if you change the behaviour of a few, the masses still have myths about mental illness. Assuming I am a mental health client who is not on any medication and battling with my condition every day, how can that reduce stigma? The stigma will not be reduced until we commit resources to address it."*
>
> (IDI, Community Mental Health Officer)

Stigma was felt to persist due to deeply ingrained cultural practices and beliefs that associate mental illness with spirituality. A traditional community leader pointed to a widespread lack of mental health literacy, with some people avoiding medical treatment due to fear of being stigmatised:

> *"Because of the fear of being tagged as having mental ill-health due to a lack of mental health knowledge, people do not seek medical care, which is killing some of them. When you are even going to marry in our culture, you have to do research and not go into a family with a history of mental illness. These are some of the things hindering the progress of the MHA implementation."*
>
> (IDI, Community Traditional Leader)

An RMHC and a Municipal Director of the Social Welfare and Community Department SWCD proposed that mental health units located within general health facilities should not be called "psychiatric departments" in order to reduce stigma further:

> *"Yes, the stigma is there. We are now finding ways and means not to label our department even as a psychiatric department because of this stigma. We have to find another way of renaming the department because when someone is coming and sees the place labelled "psychiatric department or mental health unit", the conclusion is that the person is just of no use, and that is why they are bringing the person to that unit."*
>
> (IDI_#03, RHMC)

> *"The best way to reduce stigma against people living with mental illness is to embark on social education as an awareness creation for people to understand mental illness and the need to accept it."*
>
> (IDI, Social Welfare and Community Development)

Most participants considered stigma and discrimination to have declined to some extent following the introduction of the MHA and subsequent mental health reforms. A number of participants considered integrating mental health services within general health facilities to have contributed to improved recognition of and support for mental illness. Some participants thought that although stigma had declined since the implementation of the MHA, much remained to be done to ensure a significant reduction in stigma and discrimination against people living with mental ill-health. There was a widely held view that central Government needed to support mental health reforms by allocating more resources towards public education and service redesign, integrating mental health services in primary healthcare.

6.7 Awareness and knowledge of the MHA

Awareness and knowledge of the MHA among the public were reported to be low despite Government efforts at raising awareness among the public. Although some key stakeholders indicated there had been some considerable awareness of the MHA, they also revealed they were not conversant with the specific legal requirements provided in the Act. Some RMHCs and a clinical psychologist commented that the Act was passed to promote community-based mental healthcare as opposed to institutionalisation. These participants pointed out that some mental health service providers and other key stakeholders have become better informed about the MHA; however, this has not been a sustained practice since the passage of the Act in 2012, and the need to increase public awareness about the Act:

> *"I know the MHA was passed into law in 2012, and we had a seminar on it during the early days of the passage. We have not had any other briefing or seminar on it. So, we know the law has come to streamline some of the practices and particularly curb the abuses that go on at some informal institutions such as the prayer camps and shrines and empower the districts to provide quality mental health services to patients."*
>
> (IDI, Clinical Psychologist)

> *"Mental health nurses and other key stakeholders were trained on the MHA. They are aware of the MHA's existence, their responsibilities as service providers towards caring for people with mental or psychosocial disabilities, and their duty to propagate the MHA to patients, other health workers, and the general public."*
>
> (IDI_#06, RMHC)

In contrast, An RMHC felt mental health awareness had increased among the general public as a result of the introduction of the MHA and with the GMHA advocating for mental health policy development and implementation:

> *"Yes, the overall implementation of the MHA since 2012 has brought a new revival in mental healthcare; at least everybody is getting to know what mental health is and is bringing much*

interest from various stakeholders on mental health, which previously was not there. The GMHA is doing its best to propagate or propose specific policies to improve mental healthcare. So, there have been some positives, and we appreciate it. The only thing is that our expectation of progress is higher than the delivery so far, but we have seen some positives."

(IDI_#09, RMHC)

Notwithstanding the level of information provided about the MHA, a number of community psychiatric nurses indicated they had limited understanding of the MHA:

"I heard about the MHA, but I have not gone through it, so I do not know the exact content."

(FGD_#04, Community Psychiatric Nurse)

"About the MHA, I remember a few highlights regarding the establishment of the GMHA, which will be established as an independent agency from the GHS."

(FGD_#01, Community Psychiatric Nurse)

A medical superintendent and a community mental health officer confirmed that some health professionals are not conversant with the statutory requirements of MHA:

"Some health workers are not aware of the MHA's existence, not to talk about the clients, some of whom are not literates to be able to understand it."

(IDI, Medical Superintendent, Municipal Hospital)

"I will say we are responsible for propagating the message about the MHA, we should have been educating people about the Act, but as a practitioner, I only heard about the Act but do not know much about it. I have never attended any workshop concerning the MHA. We do not know exactly what it entails. If the consumers are not aware of the MHA, I do not think that we have achieved our objective for passing the Act."

(IDI, Community Mental Health Officer)

A number of the participants were critical of the Government's approach to raising community awareness of the MHA's introduction; it was claimed that the structure necessary to achieve maximum community penetration was lacking. Accordingly, it was felt that a large percentage of the public did not understand their rights and responsibilities under the MHA. It was argued that priority ought to be given to educating targeted groups such as mental health service users and carers, frontline health workers and the general public about the legal provisions of the MHA.

Policymaker and community opinion leader participants considered that although there had been steps to publicise the MHA, knowledge about its provisions remained low. Vulnerable

people are more likely to seek services if they know about their rights under the Act. Municipal Directors of health services and the health insurance authority indicated that while there had been some education about the MHA, more needed to be done, especially in under-resourced communities. These participants further commented that many people living with mental illness and their carers remained unaware of the MHA due to illiteracy and inadequate education about the provisions in the Act:

> *"Education about the MHA has been done. However, I do not think a lot of people with mental illness know about the Act; maybe a few that are enlightened may have heard about it. Moreover, in our Municipality, most people have no formal education, so we need to do a lot more sensitisation for people to understand the MHA. We need to find a way to educate those in rural and deprived communities about the Act."*
>
> (IDI, Municipal Director of Health Services)

> *"The level of awareness about the MHA among mental health service users is very low. As I said, even close families or carers are not aware of this Act and its content and the benefits thereof, so we need to step up education and sensitisation."*
>
> (IDI, Municipal Health Insurance Authority)

A representative of a mental health NGO stated that dissemination of public information about the provisions of the MHA was ongoing, being facilitated through Government and the NGO sector:

> *"Apart from the GMHA, other actors such as BasicNeeds Ghana, an NGO, have taken up publication of the MHA at various angles and are doing that to ensure that people with mental illness know about the MHA. But it is also true that a lot of dissemination still needs to be done for many people to get to know more about the law."*
>
> (IDI_#01, NGO)

Another NGO representative also considered disseminating the MHA had been undertaken, although knowledge about it remained limited. Once again, insufficient funding was raised as a factor limiting dissemination. Awareness of the MHA will be achieved through effective advocacy for funds and services:

> *"Knowledge about the MHA to a large extent is limited because the funding to be able to disseminate information about the Act is a challenge, but at least as a civil society organisation, we have been able to disseminate some key aspects of it, not all though but at least we have been able to provide information to members on some key areas of the MHA."*
>
> (IDI_#02, NGO)

Arguing similarly, another NGO participant cited illiteracy as a reason for limited public awareness of the MHA, although some awareness had occurred among persons with mental illness and their carers:

> *"We work with several hundreds and thousands of persons with mental illness and epilepsy as well as their carers in various communities. We held training sessions with them to disseminate the MHA to them. However, there are a considerable number of them who will be unable to read the Act in its entirety and be able to know what is there, but they very much understand that the MHA is a law that is seeking to protect their interest and to protect them from abuse and guarantee them access to quality treatment."*
>
> (IDI_#03, NGO)

Mental health service provider participants also discussed how low education levels and lack of awareness of the MHA were challenges in implementing the Act. While some participants considered there had been considerable education about the MHA, others felt that the MHA's knowledge among the public was low. Some health services providers, who were required to be advocates for implementation, also lacked knowledge of the MHA. Although a formal assessment of the MHA's penetration had not yet been undertaken, key stakeholders in the regions and districts had become more aware of the need to facilitate the implementation of the MHA. An RMHC reported:

> *"We have sensitised key stakeholders, such as the Police and Prison services, TFHs, health workers, and other key stakeholders. We have sensitised them at the various Regional and District levels. We have empowered our acting District coordinators, who have also started sensitising the public."*
>
> (IDI_#10, RMHC)

Similarly, a senior psychiatrist commented that some education about the MHA has been undertaken for key stakeholders but struggled to quantify the extent of penetration as a formal assessment had not been carried out:

> *"I have had some outreaches in certain facilities or institutions outside my institution to talk about the MHA, educating health practitioners, community members, Police personnel, District Assemblies, teachers, and students about the law's existence and its applicability. Regional and acting District mental health coordinators have also been embarking on public education and advocacy about the MHA. Indeed, it is difficult to quantify how far the Act has penetrated."*
>
> (IDI_#02, Psychiatrist)

A community psychiatric nurse stated that general information was being provided through local radio and via face-to-face community education sessions, which focussed on rights, responsibilities, and roles under the Act:

> *"To a large extent, I will say people with mental conditions and their relatives may have heard about the MHA through the sensitisation that was done via radio and face-to-face training after the passage of the Act. So, most information about people's rights, roles, and responsibilities have been made known to the general public."*
>
> (IDI_#04, Community Psychiatric Nurse)

Like public policy, the law can seem remote and difficult to understand for ordinary people on the street. Two RMHCs suggested that for the general public to become more familiar with the legislation, there will need to be repeated funded public awareness campaigns:

> *"In my region, we have done education about the Act and spelt out all the key stakeholders' responsibilities towards implementing the Act. However, I think education should be a routine activity; it should not be just for a specific period. Some of us are sensitising the public on radio and TV stations. People may not be entirely aware of all the provisions in the Act, but they know a few of them related to their rights and responsibilities."*
>
> (IDI_#09, RMHC)

> *"To some extent, people are aware of the MHA because we did provide education about the MHA in 2016. The GMHA led training workshops about the Act for key stakeholders across the country. Some of the key stakeholders that participated in the workshops included the GHS staff, Ghana Education Service (Reeves et al.), Social Welfare, the Judiciary, the Police and Prison Services, mental and non-mental health workers. We did some radio sensitisation programs too. We have also advised our clinical staff to do one-on-one education for patients who visit the health facilities."*
>
> (IDI_#08, RMHC)

Mental health service providers indicated they included education concerning changes under the MHA in their daily clinical practice when working with service users and their carers. One of the RMHCs echoed the views of some of the service providers:

> *"When people with mental illness visit the health facility with their relatives, they take the opportunity to sensitise them about the law; not all of them will be aware. Still, I think a few will be in the known, and maybe those of them whose relatives are literates may have come across it."*
>
> (IDI_#10, RMHC)

On the contrary, two mental health service users appeared to have little or no knowledge of the MHA, thus confirming the position of other participants about the lack of publicity of the MHA:

> *"I only heard from a community mental health nurse that Government is working on an MHA, but we have not seen anything apart from what they told us when we come for meetings. So, I do not know much about the MHA."*
>
> (FGD_#01, Mental Health Service User)

> *"Up till now, I do not have any knowledge about the Act. Nobody has introduced the Act to us."*
>
> (IDI, Mental Health Service User)

A clinical psychologist commented that in their experience, most mental health service users and their carers remained unaware of the MHA:

> *"Most of the people living with mental illness and their carers are not aware of the MHA. We have a forum where we interact with our clients and their carers almost every two weeks, but nobody seems to know anything about the Act. So, education needs to be done to create awareness."*
>
> (IDI, Clinical Psychologist)

A community psychiatric nurse thought it likely that few people living with mental illness and their carers would be aware of the MHA as so far, dissemination of information on the Act had been very poor:

> *"I will say a smaller number of people with mental illness and their carers may have some information about the MHA. We have failed as a nation to ensure that the Act is well disseminated to the public."*
>
> (FGD_#03, Community Psychiatric Nurse)

A senior psychiatrist attributed low awareness of the MHA partly to people's inability to read and write, which is widespread among mental health service users throughout regional Ghana. This participant suggested the use of other media in disseminating some of the materials of the MHA for people to understand:

> *"I do not think mental health service users are aware of the MHA. In terms of education regarding what the Act is all about, the GMHA printed booklets explaining in simple terms, what is in the Act, and distributed to some patients in the past. But of course, some of them cannot read or write, which is a challenge. I think that we should have other media for disseminating information about the MHA through the local language."*
>
> (IDI_#01, Psychiatrist)

A CMHO and a CPO both felt some people might have heard something about the MHA, and a few could have a detailed understanding, most would have no awareness of the Act; they linked this to a lack of public education about the mental health reforms:

> *"I would not say we have done enough publicity about the MHA yet. Maybe few people might have heard something about the Act but not into details, just like me here. I can say that the masses are not aware of the Act because of a lack of concerted public education."*
>
> (IDI, CMHO)

> *"Up to date, some of the community members, chiefs, and other opinion leaders do not know that there is something called MHA in the system because education did not go down to the various communities."*
>
> (IDI, CPO)

A pastor of the Pentecost Church admitted to having very limited knowledge of the MHA:

> *"I went to Sunyani for a meeting with other pastors; that was when I heard that the Government had banned the use of chains on people with mental illness. That is all I know about the MHA. If not because of that ban, I would still be using chains, but I no longer use the chains even though I still have them here. If you do not use the chains, some people with mental ill-health can be very difficult to manage."*
>
> (IDI, Pentecostal pastor)

There was a lack of understanding that some mental illnesses could be classified as forms of disability; hence people with mental illness are not included as beneficiaries of social protection programs for people with disabilities. According to an RMHC, there is a widely held view that disability refers only to those with a physical disability; this points to the need for education for key stakeholders:

> *"Most people think that disability is just physical; they do not know that psychosocial and intellectual disabilities are also forms of disability, so sometimes it is even difficult for persons with mental illness to access the disability funds. Education about the MHA needs to disabuse people's minds on this narrow definition of disability."*
>
> (IDI_#09, RMHC)

Some community psychiatric nurses considered their work to be impeded by a lack of transportation and other logistics that would enable them to offer public education about the MHA. While there may be some awareness of the Act among well-educated members of the community, this was not the case more generally:

> *"Yeah, I think few people with mental illness in the elite class would be aware of the MHA. We currently do not have the means of transport and other logistics to disseminate information about the MHA to people in the communities."*
>
> (FGD_#01, Community Psychiatric Nurse)

A major criticism of the Government's MHA awareness campaign was that it primarily focussed on urban-based stakeholders. There was little penetration into community mental health professionals, service users, and carers. A community psychiatric nurse suggested there had been inadequate publicity about the MHA. Also, the publicity that had occurred was limited to those in urban settings who had access to social media:

> *"There is inadequate education about the MHA since its inception. I followed the media very well. On a few occasions, you will see the chief Psychiatrist and a few other mental health professionals talking about the MHA on TV shows. So, how many people in the villages have access to social media and TV? They do not get it."*
>
> (FGD_#01, Community Psychiatric Nurse)

An RMHC confirmed some key stakeholders had received training about the MHA, but there were no resources for implementation:

> *"Some key stakeholders, including the Police Service and Social Welfare department in my region, have been educated about their responsibilities under the MHA. Still, these agencies do not have the resources such as vehicles to implement those things provided for in the MHA."*
>
> (IDI_#01, RMHC)

This view was supported by a community mental health nurse, who pointed to the lack of resources for mental health education as being part of the problem of low mental health literacy in the community:

> *"People are not aware of mental health issues in general, and the major challenge is the lack of means of transport to the communities for education. There is no vehicle, no motorbike, and even where there is a motorbike; there is no fuel. For instance, my supervisor once sent me to one community in the Kintampo Municipality to educate epilepsy. I was shocked that about 98% of the people present that day thought epilepsy is spiritual and contagious."*
>
> (FGD_#02, Community Psychiatric Nurse)

An RMHC also stated that inadequate public education about the MHA was due to a lack of funding. Mental healthcare does not generate income, and therefore, it is always challenging

to get resources, including means of transportation for community outreach programs to promote mental health activities:

> *"We have not done enough education about the MHA at the Districts and Regional levels because management always tells us that mental health does not generate funds. They will not even sponsor the workers for outreach programs to educate the public about mental health issues."*
>
> (IDI_#01, RMHC)

Some participants suggested strategies to improve the dissemination of the MHA. A community psychiatric nurse suggested an inter-sectoral collaboration involving the GMHA, the National Commission for Civic Education (NCCE), and municipal health directorates was necessary to educate the public about the MHA:

> *"We have the NCCE agency that we can partner with to educate the public about the MHA. We also have the health promotion wing of the Municipal Health Directorate, which we can partner with to provide education about the MHA through the radio stations and megaphones on pickups at the community level. The only challenge will be the lack of logistics."*
>
> (FGD_#01, community psychiatric nurse)

A mental health service user suggested that the GMHA should educate the public, especially those in the communities, about the legal requirements of the MHA:

> *"I can say that the GMHA should be up and doing; they should try to educate people at the grassroots about the MHA and mental illness to understand their rights and responsibilities."*
>
> (IDI, Mental health service user)

A senior CPO echoed the point raised by the mental health service user, confirming the significance of educating the general public, especially service users, to understand their rights and responsibilities under the new mental health regime:

> *"Some people do not know that there is something called MHA, so I think that we have to intensify public education so that people, especially mental health service users, will become aware of their rights and responsibilities under the Act."*
>
> (IDI, CPO)

> *"We need to do more education for people to understand the MHA. Education is deficient, and so, there is a lack of awareness among people about the MHA."*
>
> (IDI, National Commission and Civic Education)

Attempts have been made to educate the public about the requirements of MHA. However, most of the participants reported limited knowledge of the MHA's legislative requirements in this study. Most participants agreed that the Government's awareness campaign about the MHA had limited social penetration. The reason for this low awareness was attributed to a lack of funds for public education, and also poor levels of mental health literacy in the communities. The lack of adequate knowledge potentially limits the effective implementation of the MHA and mental health reforms in Ghana. Participants considered the need for funding to be allocated for publicity of the MHA so that people get to understand their rights and responsibilities as prescribed by the MHA.

6.8 Chapter summary

In this chapter, research participants discussed progress made in implementing the MHA, passed into law in 2012. The themes reported within the chapter included increased mental health staffing and services, access and affordable mental health services, integration of mental health services, discrimination and stigma reduction, and knowledge and awareness of the MHA by key stakeholders.

Most participants considered there had been some progress in the implementation of the MHA since its introduction; this included the establishment of the GMHA with a governing board, integration of mental health services into primary healthcare, and expansion of the mental health workforce through the appointment of RMHCs and Regional mental health sub-committees to administer and supervise mental health activities across all Regions in Ghana. It was reported that mental health services were now available at all regional hospitals throughout Ghana. The establishment of mental health services in other health facilities and the introduction of paraprofessionals have directly increased access to mental health services. However, the participants also argued that access did not result in affordable mental health services due to the consistent lack of psychotropic medicines at the health facilities. Also, mental health services, although expanded, were still largely limited within remote settlements.

Some participants felt that the introduction of the MHA had contributed to reducing stigma and discrimination against people living with mental illness. While some policymakers and community opinion leaders, including NGO representatives, argued that stigma has declined due to the implementation of aspects of the MHA, most mental healthcare providers at the community level had a contrary view, arguing that the struggle to reduce stigma and discrimination was really only beginning and much greater resources would be needed if these key areas of concern were to be addressed.

Although a number of the participants held different opinions about the progress made through the introduction of the MHA, other participants felt there had been superficial progress in the overall implementation of the MHA. Some participants argued that the awareness campaign by health authorities about the MHA had limited social penetration. Lack of funds for public education and low level of mental health literacy were discussed as limiting factors. These barriers identified by the research participants that are affecting the implementation of the MHA are discussed in Chapter 7.

Chapter 7 Stakeholders' perspectives on barriers to implementing the MHA

7.1 Introduction

This chapter reports the findings of qualitative interviews and focus group discussions with relevant stakeholders in the mental health sector in Ghana. The primary purpose of the qualitative study was to document barriers to implementing the MHA, passed into law to guide the development and provision of quality mental health services in Ghana. Chapter 7 commences with an overview of the challenges of implementation and is followed by a discussion of each of the main barriers identified by these key stakeholders. Excerpts from the interview transcripts are provided as examples of the views expressed by the research participants. The chapter concludes with a summary of the challenges identified and reasons for the slow implementation of the MHA.

7.1.1 Challenges

Implementation of mental health policies and programs in most low-and middle-income countries faces many challenges. Ghana is not exempt as the mental health system in place under colonial rule never adequately addressed the needs of the native population, focusing instead on the health and mental health of the European colonial masters (Asare, 2010; Doku et al., 2012; Roberts et al., 2014). The study participants identified the following as the barriers thwarting the implementation of the MHA: inadequate funding, lack of political will, absence of a LI, inadequate logistics, insufficient mental health workforce, staff safety and motivation, lack of advocacy and awareness, stigma and discrimination, cultural beliefs, low mental health literacy and the negative cycle between mental ill-health and poverty. The interviewees' findings are presented by stakeholder group. All participants either had personal experience of mental health problems, their own or those of a close family member, or were directly involved in facilitating the MHA implementation. The findings are ordered according to these themes which also align with the WHO Health System Framework that focussed on these as important considerations for improving a health system.

7.2 Inadequate mental health financing

Aside from public funding, including internally generated funds, mental health services in Ghana are also funded by international development agencies such as the United Kingdom

Foreign, Commonwealth and Development Office (UK FCDO) and NGOs, including Basic-Needs Ghana and World Vision (Roberts et al., 2014). Revenue is not generated from mental health services since these services are required to be provided free of charge under Government policy. Nonetheless, people living with mental illness and their family caregivers face having to pay for psychotropic medication as Government supplies are often insufficient and unreliable (Ae-Ngibise, Doku, et al., 2015; Dixon, 2012; Oppong et al., 2016; Roberts et al., 2014).

Inadequate funding for mental health services was the most critical barrier identified by almost all the stakeholder groups contributing to the poor implementation of the MHA. Some participants indicated that funding of the mental health sector in Ghana depends heavily on external donor grants, which is viewed as unsustainable. Others concluded that the lack of adequate funding for mental health is a result of the low priority given to it; it was felt that the central Government has funds for other projects to the neglect of mental health.

One group of participants comprised policymakers and implementers, including senior civil servants, law enforcement officers, and parliamentarians. These participants focused on inadequate funding as an important barrier. In Ghana, international donors such as the UK FCDO impose restrictions on what their funds are used for (Doku et al., 2012; Roberts et al., 2014). The FCDO will not fund operational or running costs. One senior mental health administrator said:

> *"FCDO funding has its limits, they will not fund the operational cost, so when it comes to having money to render operational activities, which include public education, going from house-to-house, media engagement, we are not able to be supported by FCDO."*
>
> (IDI, Senior Mental Health Administrator)

At the local or District levels, there is no specific budgetary allocation for mental healthcare. At best, a percentage of the central Government's District Assembly Common Fund (a Development Fund designed to ensure equitable distribution of national resources for development in every part of the country) is allocated to the Department for Social Welfare and Community Development, which traditionally was intended for people living with various physical disabilities. People with psychosocial disabilities were not included in this social intervention program; however, this is gradually changing to include psychosocial problems in some of the districts:

> *"There is no budget specifically for people with mental illness in the Municipal Assembly."*
>
> (IDI, Municipal Finance Officer)

So far, central Government has not made funds available for these operational costs, making mental healthcare delivery a challenge. Mental health service managers struggle to make use of the limited funds that are provided:

> *"The Government is not providing the GMHA with money for mental healthcare, so we are handicapped, but the little that we have, we have been doing what we can, but a lot more needs to be done."*
>
> (IDI, Senior Mental Health Administrator)

A sitting Member of Ghana's 7th Parliament added that the delay in passing the LI required for implementing the MHA can be attributed to a lack of funding:

> *"The law envisaged creating a mental health fund to mitigate that challenge, and to that extent, since 2012, funding has not been addressed, and the main reason is lack of funding."*
>
> (IDI_#01, Member of Parliament, Ghana)

Another legislator discussed the effect of excessive bureaucracy in releasing funds that have been approved as an impediment to progress. In his opinion, the MHA was passed to address this situation:

> *"Well, I think the bottom line is the unavailability of funds. I have seen that sometimes we approve the budget, but when it comes to the releases, it is a different ball game altogether because of administrative delays. Unfortunately, the GMHA seems to be suffering."*
>
> (IDI_#02, Member of Parliament, Ghana)

Annually, there is an approximate 90 per cent shortfall between the budget set as adequate to administer specialist mental health services to patients and the amount that is subsequently provided. One of the senior administrators of mental health commented on the severe implications of the lack of funding for the mental health sector and the compensatory strategies that administrators are forced to implement:

> *"At the end of the year, the psychiatric hospitals would have received less than 10 per cent of what they require and budgeted for by Government, so it is a major problem. So, how do you live if you are only receiving less than 10 per cent? So, we live basically on loans; we ask creditors and suppliers to bring their foodstuffs on credit and our debt keep increasing over time, so funding is a significant problem facing the overall implementation of the MHA."*
>
> (IDI, Senior Mental Health Administrator)

Conventional mental health service providers were another group of stakeholders who reported that inadequate funding is a barrier to MHA implementation. These mental health services providers included community psychiatric nurses, psychiatrists, District and Regional mental health officers, psychologists, and general clinicians. One participant in this group suggested that as mental health treatment is free of charge and thus generates no income, investing in the mental health sector is not seen as a priority by Government:

> *"The Government depends on internally generated funds to fund some activities, but mental health does not generate funds. So, it is one of the barriers, and it makes the work sometimes unpalatable, but we have no choice than to hope for a better future and always be in the expectancy of manna elsewhere. Mental health has been neglected, and it will continue to be unless the authorities change their attitude."*
>
> (FGD_#01, Community Psychiatric Nurse)

An RMHC discussed the organisational tension that sporadically arises between Government funders and psychiatric hospital managers. Occasionally, these managers threaten Government with closing the facilities because of a lack of funding:

> *"Time and time again, you hear that psychiatric hospitals owe their creditors and have no money to maintain the facilities and are at risk or verge of being closed down, just because the Government has not released funds to these facilities. You know mental healthcare is free in Ghana, but someone must pay for whatever is being used; the food, the medicine, the other logistics that need to be there at the psychiatric hospitals, so that is the main challenge."*
>
> (IDI_#05, RMHC)

Similarly, another RMHC described how, in some instances, mental health staff are faced with having to use their personal resources to make up for the shortfall in funding provided by the Government:

> *"The financial resource is where we have the challenge, the Government is not committed to supporting mental health, that one, the Government is not doing well, and that is where the challenge is, mental health officers have to use their pocket money to carry out some activities just to generate data and submit which is very bad."*
>
> (IDI_#03, RMHC)

A senior psychiatrist also raised inadequate mental health funding, highlighting generational neglect of investment in mental health policy, operations, staffing, and training. He considered that funding was needed for training mental health personnel, developing policies, and building and maintaining health facilities:

> *"There has always been a funding gap because you will need funds to train people, funds to provide services, build facilities or structures, and even develop policy-like documents to ensure that the dictates of the mental health law become a reality."*
>
> (IDI_#02, Psychiatrist)

A medical superintendent of a municipal hospital believed that while the Government might be committed to improving mental healthcare, as indicated in the passage of the MHA, funding for its implementation has been delayed:

> *"I believe that there is some level of commitment from the Government to implement the MHA. Of course, this implementation will come with the necessary funding, which is where the problem is currently. Funding and setting up the necessary structures for implementation have been delayed."*
>
> (IDI, Medical Superintendent, Municipal Hospital)

An RMHC elaborated on the debt-dependency cycle, identifying it as the major impediment to implementing the MHA. He saw many challenges to implementing the MHA, primarily in psychiatric hospitals, but considered the major impediment to be lack of funding.

> *"The major problem facing psychiatric hospitals at all times is insufficient funding. These facilities are indebted to their creditors, those who provide them with food, utilities like toilet rolls, detergents, and other items."*
>
> (IDI_#06, RMHC)

Another RMHC questioned the extent of commitment among political leaders to adequately fund and implement the MHA. He suggested that since the passage of the MHA, there has been an expectation that Government will provide the necessary funding for implementation; however, this has not occurred due to a lack of political will:

> *"I think the main barrier now, which is not limited to my region, is the lack of political will. The law has been passed, but we know that one of the main issues confronting mental health service delivery in the country is inadequate funding."*
>
> (IDI_#07, RMHC)

This same participant expanded on how the lack of funding has negatively affected the provision of pharmaceuticals and equipment for mental healthcare delivery, not only in his region but throughout the country:

> *"Inadequate funding has been a big challenge for mental health service delivery. Without funding, it is difficult to get access to medication; without funding, it is challenging to get motorbikes, bicycles, vehicles to administer mental health services."*

(IDI_#07, RMHC)

It was considered that this lack of progress was largely due to inadequate resource allocation from the central Government. A community psychiatric nurse believed that so far, there had been little or no progress in implementing the MHA, and the expectations of many health professionals were not being met, the resources needed for implementing the MHA are not available, and health authorities are paying lip service to putting it into effect:

> *"I will say not at all. It is not even partially achieved because we are still in a state where medications are always in short supply. Here, we can talk about other therapies, but our major need is the drugs that are not always available. Moreover, we are talking about taking patients off the streets. Who will take care of these patients? Who is going to pay their bills? You pay for feeding and medication; you pay for everything, including laboratory tests. Health Insurance does not cover most of their treatments. So, the MHA has not achieved much yet. It is not meeting our expectations."*

(FGD_#02, Community Psychiatric Nurse)

A clinical psychologist stated that whilst mental health professionals are committed to establishing the care required, the new policy direction has not been supported by mental health funding as prescribed within the Act. Therefore, the slow implementation to date has been due to the failure to set up the mental health fund to align with the MHA priorities:

> *"We all have concerns to raise about the slow nature of implementation of the MHA. We had made formal contacts with the health authorities, and we are told that the mental health fund was yet to be established, which was the key problem inhibiting the MHA implementation."*

(IDI, Clinical Psychologist)

Furthermore, regional mental health sub-committees which have a responsibility to implement the requirements of the MHA have not been established due to failure by the Government to establish the mental health fund:

> *"The regional mental health sub-committees have been established. These sub-committees, which are supposed to act as the managing boards for mental health activities in the regions, are not functioning due to lack of funding."*

(IDI_#09, RMHC)

Another area that some RMHC thought had not progressed well was the lack of funding supporting mental healthcare at the district level. The mental health levy, which was mandated under the MHA, had not yet been established. Whilst the MHA stipulates the contractual and statutory requirements for the provision of mental healthcare, the lack of committed funding

continues to be intermittently substituted through donor funding, which was considered a major setback for implementing the MHA. Two RMHCs raised concerns regarding the lack of funding for mental health, which is affecting the implementation of the MHA:

> *"There are no funds for mental health activities, especially those in the Districts, but we have funds drip-fed from the GMHA, supported by the UK's Department for International Development for training and organisation some key mental health programs. However, there is no funding for mental health activities."*

(IDI_#02, RMHC)

> *"The mental health fund has not yet been established even though the fund was launched, the central Government has not yet determined where funding for mental health would come from, so there is a lack of progress in that direction. The district mental health coordinators have not been appointed, as the Act required."*

(IDI_#08, RMHC)

The issue of donor money substituting for prescribed government revenue was further highlighted by another RMHC who observed that the introduction of the MHA had generated interest in donor support for mental healthcare:

> *"The financial support, has improved a bit because we now have donor partners supporting mental health activities; though not so adequate, at least we have something from donor partners that keeps us going."*

(IDI_#09, RMHC)

Several participants among the community opinion leaders group commented on inadequate funding as one of the barriers to implementing the MHA. This group included representatives of NGOs as well as traditional community leaders. A senior administrator of an NGO commented on the Government's lack of interest in funding mental health:

> *"You and I know that money was found to create new regions, money was found to start free Senior High School in Ghana, but just to have the mental health LI passed and a mental health fund set up, it discourages the powers that be from doing that."*

(IDI_#01, NGO)

Another participant from an NGO argued that underfunding of the state psychiatric hospitals is a major inhibiting factor in implementing the MHA. According to this participant, the lack of appropriate funding resulted in the inability of health facilities to provide primary mental healthcare for patients:

> *"Health facilities do not have the funding required to operate and attend to the patients, especially proper feeding, proper accommodation and bedding, and other logistics. So, that*

is the challenge faced by psychiatric hospitals. Psychiatric hospitals are under-resourced, just as many aspects of mental healthcare in Ghana."

(IDI_#02, NGO)

A traditional community leader, who is also a health committee chairperson in a Municipality, added that inadequate funding, which resulted in lack of necessary logistics, is affecting Ghana's mental healthcare delivery:

"There is insufficient medicine in the mental health facilities due to a lack of funding. I hope the central Government can correct this and ensure medication supply is regular."

(IDI, Traditional Community leader)

A primary carer of a mental health service user also added to the discussion of inadequate funding for mental health:

"The health facilities should be provided with financial assistance to buy some of the medication with the money for the patients because the Government is not supplying the required medication. The Government has delayed in providing the necessary resources for mental healthcare; they say it all the time, but we do not see anything."

(FGD_#02, Carer of a Mental Health Service User)

While key stakeholder groups identified inadequate funding as a barrier, this was predominantly a focus for some groups such as policymakers, community opinion leaders and mental health service providers, but not so much for mental health service users and carers. Low levels of education and lack of awareness of the MHA may have accounted for the small contribution from mental health service users and carers. Some participants stated that funding for mental health is heavily driven by donor organisations which is unsustainable because donor funds are time-bound and use-specific. There is no dedicated budget allocation for mental health activities at the district level, and sometimes mental health workers use personal funds to settle bills for transportation and psychotropic medicine. Participants concluded that underfunding for mental health reflects poorly on the Government, which directly impacts the slow implementation of the MHA.

7.3 Insufficient supply of psychotropic medicines

Whilst access to psychotropic medication is one key aspect of contemporary mental healthcare, it was widely cited by all participants in the study as an example of the lack of consistency in the implementation of the MHA:

> *"We have not seen any impact on implementing the MHA because the drugs that are supposed to be procured for the hospitals are not there. If we get any psychiatric cases, we have to write for them to go outside and buy."*
>
> (IDI, Clinical Psychiatrist Officer)

A mental health service user considered the rising incidence of people presenting for treatment for mental illness is linked to inconsistency in supply of psychotropic medication. According to this participant, medication supply had been available in the past but could not currently be obtained:

> *"The number of people getting severe mental illness is on the rise because the drugs that used to be free and readily available are no longer there for us, which has led to an increase in the number of people with severe mental illness."*
>
> (FGD_#01, Mental Health Service User)

Mental health service providers as a stakeholder group also expressed apprehension about the lack of logistics for mental healthcare, which affects the implementation of the MHA:

> *"We do not get enough psychotropic medicines. We sometimes have to use our pocket money to buy medicine for our clients, but how sustainable is this?"*
>
> (IDI, Community Mental Health Officer)

An FGD participant identified a lack of psychotropic medication for patients with mental disorders as the most important challenge negatively affecting the implementation of the Act. As noted by this participant, patients are sometimes given a prescription to buy the medicine themselves even though mental health services are supposed to be provided free of charge to patients and their carers from low socioeconomic backgrounds:

> *"For the challenges, they are numerous. Medication remains the top challenge. We all know that by law, medication is supposed to be free for patients. However, the medication is not forthcoming. So, we resort to prescribing for patients to buy from outside, and these are poor people, and most of them cannot afford it. So, lack of medication still tops our challenges."*
>
> (FGD_#01, Community Psychiatric Nurse)

This point was further reinforced by a clinician who claimed that the MHA had not made any positive impact on mental healthcare since its introduction in 2012 because patients still pay out-of-pocket to obtain psychotropic medication (see section 6.4):

> *"We have not seen any impact on that because the drugs that are supposed to come to the hospital; we do not get them. At the moment, when we get psychiatric cases, we always prescribe medication for them to buy from outside the facility."*
>
> (IDI, Clinical Psychiatric Officer)

Psychotropic medicines were sometimes allocated only to the three main psychiatric hospitals in Ghana. The required supplies were not allocated to the community mental health units:

> *"Psychotropic medications are costly, not available, and sometimes supplied only to the three main psychiatric hospitals. I will say that we have not achieved much progress as far as implementing the Act is concerned."*
>
> (IDI, Community Mental Health Officer)

Similarly, a CPO was emphatic in claiming that the introduction of the MHA did not make mental healthcare affordable due to the unavailability of psychotropic medication for patients:

> *"I do not see any progress with access and affordable mental health services because psychotropic medicines are not available in almost all psychiatric facilities. Patients still have to pay out-of-pocket for medication."*
>
> (IDI, CPO)

Security in the face of having to work with the risk of exposure to violent and aggressive behaviour from patients has been raised as a major concern internationally (Alhassan & Poku, 2018; Konttila et al., 2018; Llor-Esteban et al., 2017). In countries such as Ghana, this concern is even more pressing because of the inconsistency of access to antipsychotic medications (Alhassan & Poku, 2018; Atinga et al., 2014; Harnois et al., 2000). An RMHC suggested that the lack of implementation of the MHA and associated operational requirements legislated under the MHA contribute to increased patient-to-staff violence. The lack of psychotropic medicines raised security concerns for staff working with newly admitted disturbed and agitated patients:

> *"Insufficient medication supply; last year, we heard attacks on staff; clients attacking staff because there were no medications. So, if there is funding throughout the three psychiatric hospitals, there will be medications for patients who need them."*
>
> (IDI_#02, RMHC)

A senior administrator of health services admitted the progress made with the implementation of the MHA also added to the strengthening voice concerning the inconsistent supply of

psychotropic medication for mental healthcare as expressed by other participants (see section 7.3):

> *"Yes, there has been some improvement in mental healthcare, but the mental health units are not getting the needed medicine for patients. Community psychiatric nurses go to communities for outreach programs without psychotropic medicine for patients; this needs to change."*
>
> (IDI, Municipal Director of Health Services)

Further, on the theme of affordability, an RMHC emphasised that patients still had to pay for medications and related services under the MHA, as medications were not always available free of charge in public health facilities. Participants affirmed the lack of resources as a major bottleneck for implementing the MHA:

> *"No, mental health services are not affordable. By the MHA, treatment for mental illness is supposed to be provided free of charge, but these services are practically not free because of insufficient resources. Patients still have to pay for their medications and all other services, especially if they were not registered under the NHIS and the central Government did not supply the medication."*
>
> (IDI_#02, RMHC)

Apart from the reported perennial shortages of psychotropic medicines that necessitated out-of-pocket procurement of medication by mental health service users, there is also the issue of regional imbalance in the distribution of mental health facilities discussed under lack of resources for implementing the MHA (see section 7.6).

7.4 Political will and leadership

Studies have documented the unwillingness of Governments in low-income countries to commit resources to mental healthcare (Doku et al., 2012; Eaton et al., 2011; Lund, Mental, et al., 2010), resulting in unsatisfactory mental health service delivery for people living with mental illness. Many study participants questioned the political commitment and understanding of decision-makers to the importance of implementing the MHA. For most study participants, mental healthcare has not been a priority for different political administrations in Ghana. This lack of political commitment and leadership was thought by some participants to be evident in the low prioritisation given to mental health generally in Ghana; this was seen to be a significant barrier to implementation of the MHA. The need for further Government investment in mental health was seen as crucial by most participants.

Policymakers and implementers believed that there is no political commitment and leadership to mental healthcare in Ghana. A key policymaker was critical of some mental health stakeholders claiming that they had not played their part to ensure mental health is given the necessary attention. Commenting on the progress of mental healthcare in Ghana, he said:

> *"Very little progress of implementation. We need to do more as a country. There are no drugs, no resources, and inadequate personnel to handle mental health issues. Maybe all of us do lip service to mental health issues and not attaching any importance to it."*
>
> (IDI, Municipal Health Insurance Authority)

Another policymaker indicated that political commitment towards mental healthcare is low compared with other health conditions in Ghana. He assigned a probable reason for this lack of commitment to the effect that mental illness is not fatal as compared with other illnesses, and that may account for the low importance given mental health since resources are scarce and needed to be allocated based on priority:

> *"Frankly, I will say the commitment to mental health is relatively low and that is why we need to keep on reminding central Government. I must say it may also be in part because the national cake is small, then, Government will tend to give attention to the sectors of high fatality."*
>
> (IDI, Senior Mental Health Administrator)

Similarly, a law enforcement officer commented:

> *"Oh, central Government is not serious about mental health. It only waits for a big problem to occur before moving to provide some support. So, our Governments are not serious about mental health."*
>
> (IDI, Divisional Commander of Police)

A senior policymaker further pointed to the gap between implementation of the MHA and the required resourcing because mental health had not yet been given sufficient attention, and this has a negative effect on the work of mental health staff.

A mental health service user also commented on the lack of progress in implementing the MHA, pointing out that while the Government provided monthly support for other disadvantaged groups albeit, those with mental ill-health were not included. This service user added that benevolent individuals and organisations provided some of the medications obtained from hospitals. As previously suggested by an RMHC (see section 7.2), this participant considers that donor aid is substituting for, rather than supplementing Government spending on mental healthcare:

> *"We have seen nothing about the impact of the MHA. Due to sickness, people see us differently. They do not regard us as important because other groups of people that the Government is supporting, like persons with disabilities, orphans, and others. The Government assists these groups every month with stipends but neglects those of us with mental ill-health. So, when we even get medication from the hospitals, it is probably from various people and institutions' kind gestures but not from the central Government."*
>
> (IDI, Mental Health Service User)

Mental health service providers also discussed the lack of political will towards mental healthcare, resulting in the MHA's slow implementation. An FGD member was adamant and emphatic that inadequate progress in implementing the MHA was evidence of a lack of political interest in mental health. This view was held by other participants who lamented that they did not see enough commitment and political leadership from the central Government to improve mental healthcare in the country through the implementation of the MHA:

> *"Governments pay no attention to mental healthcare in Ghana."*
>
> (FGD_#04, Community Psychiatric Nurse)

The rudimentary state of mental health services in Ghana is a direct outcome of Governments failing to prioritise mental health as a component of the public health agenda. Past and present Governments have not paid sufficient attention to mental healthcare in the country. Therefore, mental healthcare is not a priority and has not been high on the reform agenda of the political authorities. This lack of political will to invest in mental healthcare was pointed out by one of the RMHCs:

> *"I think the political will on the part of Government in power at any point in time is lacking. That political will to ensure the full implementation of the MHA is lacking. For instance, I say so because they have established the GMHA without resourcing it properly to manage mental health affairs, especially the inadequate supply of Government-sponsored medicine."*
>
> (IDI_#08, RMHC)

At the regional level, a RMHC echoed previous participants, reiterating a lack of funding and low political commitment as the main impediment to the MHA implementation progress:

> *"I will say overall it remains a work in progress. Many barriers are confronting the full implementation of the MHA. Financing is one challenge; prioritisation of mental health is another challenge, but I think at the regional level what we can do, we are doing our best to ensure that the MHA is implemented."*
>
> (IDI_#05, RMHC)

Similarly, a Community Mental Health Officer in discussing the lack of progress with implementation identified that although there has been heightened awareness globally of the impact and importance of mental health, it has never been seen as a health priority by political decision-makers in Ghana. This participant considered that mental health has not featured on the policy reform agenda:

> *"A major barrier is coming from the policymakers themselves. Mental health issues are not part of the development agenda in Ghana."*
>
> (IDI, Community Mental Health Officer)

As crucial stakeholders, representatives of NGOs also discussed the apparent lack of political commitment toward mental healthcare in Ghana. These stakeholders pointed to a lack of central Government commitment to make resources available for Ghana's mental health services. Accordingly, this failure to commit was seen as a significant setback for the implementation of the MHA:

> *"I do not think that central Government is committed to mental health. Even if they are, they can do more. Because they have established the GMHA and are paying the workers, then we would say that is some sign of progress, nonetheless."*
>
> (IDI_#01, NGO)

> *"One of the things that the MHA has achieved is the establishment of a mental health fund, but the Government has not committed any resources into the fund. So, only donors like FCDO have committed, and that does not speak well of the country that wants to overhaul mental healthcare across the country."*
>
> (IDI_#03, NGO)

Commenting on the lack of political commitment to ensure funding for implementation, another NGO stakeholder suggested that with political support in resource allocation, one could have expected at least 75 per cent of implementation of the MHA to have been achieved in the eight years since the MHA came into existence:

> *"One of the barriers is that there is no political commitment as a Government, not only this particular Government but Governments in the past, to ensure that there is funding for mental health such that the implementation is smooth. At least, more than 75 per cent of the provisions in the MHA should have been implemented if there was political commitment."*
>
> (IDI_#02, NGO)

A mental health service user also commented on the lack of commitment and importance attached to mental health by Government, resulting in widespread stigma against people living with mental illness, unaddressed by the authorities:

> *"I will say is that the Government does not have time for us. The Government does not see the need to help us. As a whole, people are stigmatising us every day. You know our condition is always attached with stigma, which has not been addressed by the relevant authorities."*
>
> (IDI, Mental Health Service User)

Participants identified a lack of political commitment towards mental healthcare as a key barrier affecting the MHA implementation. All key stakeholders agreed that both past and present political authorities had not prioritised mental healthcare as part of an agenda worth pursuing. According to these participants, the lack of political commitment to mental health is evidenced by the Government failure to commit resources to mental healthcare, resulting in a rather slow implementation of the MHA.

7.5 Delay in passing the LI

Most participants expressed the view that one of the main challenges impeding the implementation of the MHA was the Parliament of Ghana's failure to pass the LI in a timely manner to dictate the legal framework for implementing the MHA. The absence of such a legal instrument affects the allocation of funds to the GMHA to facilitate implementation. Although the LI was passed after completing the data collection for this Thesis, the mental health levy has not been established yet to provide funding for mental healthcare. The data collection for this Thesis, involving a number of key stakeholders, may have been influential in the process leading to the approval of the LI.

Some policymakers and implementers discussed this delay in passing the LI as a setback for implementing the MHA. A member of the Health Committee in the Parliament of Ghana stated that the Ministry of Finance (De Carvalho et al.) had yet to identify an appropriate funding source for the establishment of the mental health fund, resulting in the delay in passing the LI:

> *"The MoF is still looking for innovative ways of instituting the mental health fund, and I still think that it is taking quite too long to complete; the sector Minister responsible should have solved that challenge long time so that we can have a very effective mental health fund which will resource the GMHA to provide quality mental health service to Ghanaians."*
>
> (IDI_#01, Member of Parliament, Ghana)

In the same vein, a senior mental health administrator stated that:

> *"The fact that we still do not have a LI is a major, major challenge, but we hope it will soon be passed."*
>
> (IDI, Senior Mental Health Administrator)

Another legislator considered the issue from a different angle to include the fact that the LI needs to be passed so that rehabilitation services could be provided for people with mental illness who have been treated:

> *"We cannot habilitate people with mental illness when we do not have a full LI that spells out how people should be rehabilitated and integrated into society after treatment. We have this problem, which has been with us for long, and so we need to get the LI passed as a sign of Government commitment to mental health."*
>
> (IDI_#02, Member of Parliament, Ghana)

Some mental health service providers considered that the inability of central Government to identify a funding source for mental healthcare was preventing or delaying the LI from being passed:

> *"The source of funding for mental healthcare is what was in contention. I think that has been part of the matter affecting the passage of the LI. I do not know whether they have identified another alternative source to fund mental health yet."*
>
> (IDI, Clinical Psychologist)

Some RMHCs attributed the lack of importance and prioritisation attributed to mental health as being responsible for the non-passage of the MHA LI:

> *"I believe that there is an issue of lack of prioritisation of mental health. If mental healthcare was adequately or appropriately prioritised, all of these problems we are having might have been resolved by now. As a matter of fact, lack of priority or low priority and lack of understanding of mental health prevents the passage of the LI."*
>
> (IDI_#05, RMHC)

A community psychiatric nurse was of the view that it is the responsibility of the legislators to ensure that the LI is passed to facilitate funding for mental health in the country:

> *"The policymakers have to ensure that the LI is passed so that all the required resources are provided for mental health personnel to discharge their duties effectively."*
>
> (IDI_#01, Community Psychiatric Nurse)

NGO participants as a stakeholder group also expressed their opinions on the delays in passing the MHA LI to create the enabling environment for the smooth implementation of the MHA, re-echoing views of previous participants:

> *"Another significant barrier preventing the implementation of the MHA is the absence of the LI. As you know, in Ghana, we have a two-tier process for our legislations. We have the MHA, which provides a broad framework, and then you have the LI, which gives much more details as to how to implement the various provisions of the law backed by funding. So, with the MHA LI not being approved yet due to the inability to identify a funding source affects the effective implementation of the entire law as provided."*
>
> (IDI_#01, NGO)

Another NGO participant expressed the view that decentralisation of mental health services, which is a vital provision of the MHA, has not been achieved because of the lack of the LI to facilitate funding:

> *"Decentralisation has not been effectively put in place because the LI has not been activated to address the funding bit of mental health; we still have people travelling from the Northern part of Ghana to the Southern part to seek mental healthcare, which is not supposed to be the case."*
>
> (IDI_#03, NGO)

One of the NGO participants attempted to provide a reason for the delay in passing the LI:

> *"The passage of LI has been delayed because we initially thought that the funding aspect should be included, this has delayed the process because of the inability to identify a funding source by the MoF."*
>
> (IDI_#02, NGO)

A number of policymakers attributed the delay in the passage of the LI to the bureaucratic administrative process, while mental health service providers interpreted the same to mean lack of importance attached to mental health by political authorities in Ghana. A dedicated funding source for mental health is yet to be established by the Ghana MoF. Mental health service users and carers did not comment on the passage of the LI and its implications for mental healthcare. This is not a surprising observation given the generally low level of knowledge about the MHA among this group of stakeholders.

7.6 Resources

Lack of essential logistics for mental healthcare in Ghana was one of the factors identified by the study participants as impeding the implementation of the MHA. According to some participants, there are insufficient psychotropic drugs and unavailable means of transport for

community outreach programs to promote safe and effective mental healthcare delivery. Some participants from across both Government and NGOs identified the aggregation of treatment facilities to the municipal and metropolitan centres as a significant barrier to access for people living in rural and remote parts of Ghana. Some participants also indicated that access to mental healthcare remains limited in many rural areas. Mental health capital infrastructure is still currently centralised to the District, Municipal and Metropolitan centres; there are limited mental health resources at the community level. Some study participants indicated that the geographical imbalance in resourcing between Northern and Southern Ghana would remain a barrier to progress without redistribution or further capital investment. The following is reflective of participants' comments regarding the lack of logistical support for mental healthcare.

Progress, where it had been made, was considered uneven. For instance, little had been achieved in implementing the MHA beyond Southern Ghana, where mental healthcare remained concentrated. Throughout the country, stigma remained widespread for people living with mental illness and mental health professionals. In discussing these issues, a community opinion leader argued that 'local universality' of the MHA had not been achieved:

> *"Well, in terms of our expectations, we would not say there has been much progress with the introduction of the MHA. Mental healthcare is more or less restricted to the national level in Accra and Cape Coast. We still do not have a proper decentralisation of mental health services at the District levels, as stipulated in the MHA. We still have people travelling from the North towards the South to seek mental healthcare. We are also seeing that staff working in mental health services face much stigma just as the patients themselves because people do not think that we belong to the mainstream health service provision."*
>
> (IDI_#02, Non-governmental Organisation)

Policymakers discussed insufficient resources affecting the implementation of the MHA. One law enforcement officer also expressed the view that insufficient resources had been allocated to support implementation. This participant also felt that inadequate attention had been given to ensuring all stakeholders understood the MHA and its implications, and that was adversely affecting its implementation:

> *"Resources have not been provided for implementing the MHA; this is because we still see many people with mental problems roaming the streets. Some of us have also not been educated about the MHA."*
>
> (IDI, Divisional Commander of Police)

Similarly, a senior staff member of the social welfare department stated that due to failure to appoint District mental health coordinators and sub-committees, expectations had not been met regarding the implementation of the MHA:

> *"Right now, I will say there is limited progress because the MHA makes provision for the District and Municipal mental health sub-committees, but since I came here, I have not seen a meeting of that sort because these committees are yet to be established."*
>
> (IDI, Director, Municipal Social Welfare and Community Development)

The general concern regarding the lack of progress in implementing the MHA was echoed by a senior administrator of a mental health NGO:

> *"Very little. We need to do more. No drugs, no resources, and inadequate personnel to handle mental health issues. Maybe all of us do lip service to mental health issues and not attaching any importance to them."*
>
> (IDI_#01, Non-governmental Organisation)

Another policymaker stated that there is a need for resources to be committed to mental health to cater for people with mental illness:

> *"We should create resources, even the existing ones if you go there the resources are not adequate. So, we should commit resources to take care of these people."*
>
> (IDI, Municipal Health Insurance Authority)

A Municipal Director of health services indicated that there are insufficient resources for mental health staff to work within the community:

> *"…the implementation, we have some staff but inadequate resources for them to work in the communities."*
>
> (IDI, Municipal Director of Health Services)

In contrast, one of the RMHCs indicated that despite the challenges facing the implementation of the MHA, some progress had been made, including the establishment of the GMHA to oversee the implementation of the MHA and the appointment of RMHCs for ten out of the sixteen administrative regions in Ghana:

> *"The MHA has been a good start despite the numerous challenges, as you may be aware that the LI, is supposed to operationalise the law, is yet to be passed. Despite that, we have been able to make some significant strides, such as establishing the GMHA and the appointment of the RMHCs."*
>
> (IDI_#07, RMHC)

Decentralisation of service delivery is being promoted as a cornerstone of mental health reform in Ghana. Unfortunately, other participants considered that there is limited evidence of decentralisation of mental health service delivery or an increase in community-based services resulting from the MHA implementation. A Community Psychiatric Nurse, argued that there is still much concentration on the three main psychiatric hospitals in Ghana:

> *"Access to mental health services is still very limited. No logistics to work with, especially at the district and community level."*
>
> (FGD_#04, Community Psychiatric Nurse)

Further, a CMHO discussed his experience at a District level, indicating that there are no specialist inpatient units at the general health facilities to treat people with acute mental health needs. The general wards were also seen to be struggling with limited space:

> *"Patients sometimes need hospitalisation, but as you can see, we do not have places to admit people with mental illness. You send patients to the main ward, and the wards are also struggling for space. So those are the key challenges we find."*
>
> (IDI, CMHO)

A Community Psychiatric Nurse (CPN), as a frontline clinician, raised the point that the mental health sector is not seen as crucial since the introduction of the MHA, and thus the shortfall in resource allocation (see section 7.6):

> *"We are handicapped regarding logistics nationwide; sometimes it is reported on television that we have run out of psychotropic medication. As a nation, it does not speak well of us. It is a clear sign that we have relegated mental health, which in the year 2012 was even the second priority area of the Government regarding health-related areas."*
>
> (FGD_#02, CPN)

Some community psychiatric nurses commented on the Government's fragmented approach, to training and education about the MHA. According to one participant, the necessary training about the MHA has been completed for both conventional and TFHs, but resources to support implementation had not been provided:

> *"I will say one of the major barriers to implementation is the lack of logistics. After the law was passed, some mental health staff and TFHs were trained in a workshop and given information about the MHA. However, how do we spread the MHA to others without resources?"*
>
> (FGD_#03, Community Psychiatric Nurse)

Extending the discussion into the faith-healing sector and its practice of restraining violent patients with chains, this Community Psychiatric Nurse felt that it might not be possible to manage aggressive patients at these prayer camps because of the lack of logistics, including

inconsistent supply of psychotropic medication (see section 7.3), to manage patients once their chains are removed as required under the MHA:

> *"It will not be easy to go to a prayer camp and ask them to take the client off chains as the client can just abscond. If we had enough logistics to continuously visit homes and facilities to educate them about the MHA, we would be able to make some achievements. However, because there are no logistics, implementation is slow."*
>
> (FGD_#03, Community Psychiatric Nurse)

The logistics or infrastructure referred to here by the study participants included: means of transport for community educational tours; accountable impress for emergency expenses; psychotropic medicine; and extra pay as motivation for staff. It was felt that the insufficient availability of such logistics was adding to the challenges faced by mental health professionals:

> *"The major challenge is how to move from one community to the other. For instance, if I have to go to Busuama to educate people about mental health, I cannot walk because of the distance, there is no vehicle, there is no motorbike, and even if there is a motorbike, there is no fuel. How do I get there? So, the challenges are a lot, hence the slow implementation of the MHA."*
>
> (FGD_#02, Community Psychiatric Nurse)

Mental health workers at the sub-district level sometimes must depend on the itinerary of community health workers to perform their duties. The situation was believed to have resulted from a lack of ring-fenced funding for mental health at the district level. One community psychiatric nurse stationed at the sub-district level commented:

> *"Sometimes, I have to even rely on the itinerary of the community health worker or the midwife for community outreach programs. I have to join these health workers' vehicle to get to the communities for outreach activities. The mainstay of most people is farming. So, I have to always wake up at 4am to get to their communities before they embark on their daily farm activities."*
>
> (FGD_#01, Community Psychiatric Nurse)

Policymakers sometimes promise to provide logistics but fail to deliver on those promises. A community psychiatric nurse raised this in a group discussion:

> *"About five years ago, the then Director-General of Ghana Health Service] at Bawku Annual Health Review meeting, he announced that health workers would be issued with tablets to be practising telemedicine. Most of the time, the authorities say all these things just to appease us, but nothing happens when they leave the scene."*
>
> (FGD_#04, Community Psychiatric Nurse)

Two community opinion leaders pointed out that various resource constraints, including insufficient psychiatric facilities across the country were preventing the implementation of the MHA since its introduction:

> *"Psychiatric hospitals have various resource challenges, financial, logistics, and space challenges. These are certainly preventing the implementation of the MHA."*
>
> (IDI_#01, NGO)

> *"Mental Health is poorly developed at the community level, and there is still much concentration on the three psychiatric hospitals."*
>
> (IDI_#03, NGO)

To summarise, participants in the various stakeholder groups identified inadequate logistics such as access to mental health facilities, and transportation costs to provide education and clinical services in the communities as affecting mental health service delivery and directly preventing the implementation of the MHA. While mental health service providers discussed specific logistics directly affecting their routine work, policymakers discussed general logistics, calling for more mental health resources. Mental health service users and carers did not comment on inadequate resources as a barrier to implementing the MHA.

7.7 Insufficient mental healthcare workforce

Globally, most countries report an undersupply of qualified staff for their mental health systems; Ghana's situation is no exception (Lund et al., 2016; Ofori-Atta, Read, et al., 2010; Roberts et al., 2014). Many participants discussed workforce deficiencies and workforce ageing in mental health, from psychiatrists to trained mental health nurses and other allied health professionals. Some participants assigned reasons for insufficient mental health professionals to include the lack of a clear career progression pathway for personnel already in the mental health sector, resulting in high staff attrition from mental health to general healthcare and Government unwillingness to fund the mental health sector.

Many participants described insufficient human resources for mental healthcare as a significant issue to implementing the MHA. Some study participants identified a lack of staff as a challenge and lack of qualified personnel, especially at the district level, as a critical barrier to implementing the MHA.

Policymakers and implementers suggested a mutual causality between the lack of implementation of the MHA and the inadequacy of the mental health workforce. Some participants maintained that funding and insufficient personnel were the main barriers impeding the implementation of the MHA. A deputy member of the health committee in Parliament also

decried the lack of a robust human resource-base for mental healthcare delivery. This legislator commented:

> *"The major challenge for me includes an inadequate human resource for mental healthcare delivery. The GMHA is a huge institution and needs to have adequate personnel to fill the numerous positions established under the MHA."*
>
> (IDI, Member of Parliament, Ghana)

The juxtaposition between implementation and staffing was further reiterated by a Municipal Health Director who identified a need for more staff to augment existing mental health personnel in delivering effective services to mental health service users. It was suggested that accommodation and other logistics should be made available to support staff:

> *"I wished we can have more staff for mental healthcare, but these staff also need accommodation in the various communities to discharge their duties well. So, yes, we need more staff to come on board."*
>
> (IDI, Municipal Director of Health Services)

However, the Municipal Director of Health Services also indicated that mental health staffing profile had been gradually increasing due to the growing number of training institutions currently training mid-level mental health professionals both in the cities and in rural areas. This participant expressed hope that the human resource base for mental health would grow over time. Previously, Pantang and Ankaful Nurses Training Colleges were the only institutions based in the cities training mental health professionals in Ghana:

> *"For implementation, at least we now have qualified staff who are managing mental health conditions in most of the communities and facilities. Previously it was only two mental health training schools, Pantang and Ankaful. However, now the College of Health in Kintampo and the College of Health at Yamfo are training mental health professionals. So, human resources are improving over time."*
>
> (IDI, Municipal Director of Health Services)

A clinical psychologist and a key representative of an NGO bemoaned the lack of key mental health workers, which is adversely affecting mental health service provision Lack of qualified personnel, especially at the district level, was considered one of the critical barriers to implementing the MHA:

> *"Lack of personnel at the district level as you can see that, per the MHA, every District is supposed to have at least three key personnel, including the clinical psychiatric officer, the clinical psychologist and a social worker collaborating effectively with other mental health*

professionals to provide mental health services. However, most of the districts lack these personnel, which is a huge challenge to mental healthcare."

(IDI, Clinical Psychologist)

One of the RMHCs in discussing the barriers impeding progress referred to three major structural and fundamental factors preventing the implementation of the MHA. These factors included financial, human resource, and general logistics:

"We have inadequate funding, delay of vital structures, we do not have review tribunals, we do not have visiting committees in place, even though we have RMHCs appointed and inaugurated, we also need District mental health coordinators to support the work that we do. So, we need all these structures to help push the reform agenda forward."

(IDI_#04, RMHC)

Despite the ongoing shortfall at the regional and District levels of care, an RMHC acknowledged the improvement in human resources for mental healthcare resulting from the introduction of the MHA:

"With human resources at the national level improving, we are moving forward, But at the lower levels such as the Regional and District levels, we are yet to get the required number of human resources which will help deliver quality mental healthcare as the MHA proposes."

(IDI_#09, RMHC)

Another RMHC noted that the regional mental health sub-committees and RMHC positions had been established but without allocation of resources to allow these to function (section 7.6):

"Apart from the RMHCs' appointment, the Regional mental health sub-committees have also been established without the necessary funding allocation. Therefore, mental health activities have gone on slowly because of no funds. The district mental health coordinators and the visiting committees have not been appointed yet."

(IDI_#05, RMHC)

Participants considered that insufficient mental health professionals were a significant barrier hindering the implementation of the MHA. Some participants asked for more mental health professionals to be deployed into the mental health sector. Some participants noted that the numbers of mental health personnel such as social workers, District mental health

coordinators, occupational therapists, and clinical psychologists were inadequate to progress the mental health agenda and that this adversely affected the full implementation of the MHA.

7.8 Staff safety and motivation

Some participants indicated that the MHA had placed much emphasis on mental health service users but had neglected mental health service providers. For some of these participants, the risks involved in working in the mental health sector are not given adequate attention under the MHA. These participants were pessimistic regarding the MHA achieving its objectives and emphasised the need for Government as a priority to address workforce safety and management of risk.

A senior staff member of the NHIS, commented that people need to be motivated and incentivised to go into mental health. Mental health is a specialised area, and therefore people need to be motivated, first to train in that area, and second, there should be sufficient logistics to support their work:

> *"People must be motivated; mental health is a strategic area that we need people who are motivated and prepared to work there. As a policy, we should motivate people to come into that area because we need that area to survive. So, we need to provide the needed logistics to work because it is not just a department and people; it is about making logistics available for work."*
>
> (IDI, Municipal Health Insurance Scheme)

Mental health service providers extensively discussed the need for authorities to put safety measures in place and motivate staff to work in mental health to discharge their duties effectively. Two community psychiatric nurses argued that the MHA was incomplete as it failed to address the workplace conditions of mental health service providers:

> *"I see the MHA as incomplete; I think something must be done to improve work conditions for health workers. There is no risk allowance for service providers, and considering the kind of job we are carrying out, a lot of risks are involved. This Act, I thought, was going to address the system's weakness by including motivation packages for service providers because of the risk involved in our work, but this is not the case."*
>
> (FGD_#02, Community Psychiatric Nurse)

Other frontline community health nurses reinforced previous participants' views that for the MHA to be implemented, there is a need to consider the staff's motivation, as there are risks in working in the mental health sector. Sometimes, staff are abused by patients and can be injured:

> *"If Authorities want the MHA to be implemented effectively, staff should be motivated for the extra jobs they do. The threatening behaviour experienced by staff is not being compensated. If a patient hurts you in the line of duty, you have to pay the medical bills at the hospital for treatment personally. So, if I visited a patient and got a cut on my head, I will pay my bills, then what will be my motivation?"*
>
> (FGD_#04, Community Psychiatric Nurse)

Participants also lamented the lack of career pathways for mental health professionals to develop their skills further and seek promotion. In contributing to the discussion regarding barriers to the implementation of the MHA and mental healthcare generally, a community psychiatric nurse commented that notwithstanding the establishment of the GMHA, little had been done to streamline career development opportunities for junior staff in the mental health sector:

> *"The GMHA is in place right now, but the issue is that the Authority is supposed to chart a career pathway for junior staff to develop their skills further. I want to train as a psychologist, but there is no clear pathway to do that. The Authority needs to open the locked doors, career pathways, and people will take the opportunity to master certain areas that can be used as the human resource to fuel mental health development and implementation."*
>
> (FGD_#01, Community Psychiatric Nurse)

Some policymakers and mental health service providers, in recognising the level of personal risk faced by mental health workers, discussed the need for additional motivation for staff to remain in the profession. This, according to the participants, will boost staff interest since additional motivation means that staff are compensated for the risk involved in taking care of people living with mental health disorders.

7.9 Advocacy and awareness

Lack of advocacy and awareness of the MHA by relevant bodies were key areas participants identified as barriers to the implementation of the MHA. There was limited knowledge of the MHA among health service users, healthcare providers, and community opinion leaders.

Policymakers and implementers viewed a lack of awareness of the existence of the MHA and the generally low level of mental health literacy as a barrier affecting implementation. A participant from the Judicial Service indicated a need for more advocacy from the general public regarding mental healthcare in Ghana. It was suggested that lack of public advocacy was being interpreted by Government as the public not seeing mental health as a policy priority. According to this participant, advocacy was the only way for the Government to listen and act to support mental healthcare in Ghana. He supported this argument with an example of a

proposal that was initiated by Members of the Parliament of Ghana in 2019 for the nation to build a new Parliament Chamber. This proposal, however, was widely rejected by the people of Ghana through advocacy:

> *"Well, maybe Ghanaians do not realise the relevance of mental health to ask the Government to act through agitation. The proposal to construct a Parliament Chamber was dropped through this agitation; everybody talked about it, asking the Government not to invest in building a new Parliament Chamber, the Government yielded to the public pressure. However, when it comes to mental health, nobody talks about it. The law is there, but nobody cares. So, the major problem is advocacy. We have to prompt the Government to act."*
>
> (IDI, District Magistrate).

Similarly, a Member of Parliament reinforced the comment made by the District Magistrate, emphasising the need for the public to advocate for mental health to be taken seriously:

> *"The issues of vulnerable groups have to be drummed loudly by people who are interested in mental health. Furthermore, this public advocacy has been lacking."*
>
> (IDI_#02, Member of Parliament, Ghana)

Literacy is fundamental to understanding and advocating for one's rights. For some participants, not being able to read and write, together with being vulnerable including having a mental health disorder, was the reason they did not seek justice through the courts when their rights have been violated:

> *"Ignorance is a limiting barrier. People have to go to Court to seek justice. When it is a criminal offence, it has to be reported to the Police. If it is a civil case, then people can go straight to the Court to file their case at the registry. So, everybody must feel free to come to the District Court to seek redress."*
>
> (IDI, District Magistrate)

A senior staff member of the social welfare department, in expressing concern that some key stakeholders had not received any training regarding the MHA, suggested that illiteracy was a significant factor in the lack of penetration and subsequent awareness of the MHA:

> *"There is limited publicity about the MHA, even to some of the key stakeholders like me. I am a stakeholder, and I have never had any seminar or workshop about the MHA. If I did not read the MHA personally, I would not have any knowledge about it. But as a key stakeholder such as the social welfare unit, we should have been taken through the MHA so that we will be abreast with it. Some of us may read it, but the understanding may differ from how the MHA is supposed to be implemented. Also, and I think those who cannot read nor write may probably not have the opportunity to know about the MHA."*
>
> (IDI, Social Welfare and Community Development)

Another participant involved in policy implementation pointed to a lack of understanding of the MHA among key stakeholders responsible for its implementation. It was felt that public education needed to be intensified to improve implementation of the MHA:

> *"Yes, as one of the key stakeholders, especially in carrying out education regarding mental health, I have little knowledge about the MHA, and certainly not enough knowledge regarding the key provisions. People are not aware of the issues about mental health in Ghana; they are unaware of the MHA's existence. So, stakeholders need to advocate more through publicity and education."*
>
> (IDI, National Commission for Civic Education)

The Department of Social Welfare and the National Commission for Civic Education play important roles in implementing the MHA, including disbursement of livelihood support to people with physical and psychosocial disabilities and the public's education about the MHA. Lack of understanding of the MHA among staff at these agencies would likely adversely affect how some of the MHA provisions are applied to people with mental disorders.

Lack of resources (see section 7.6) for the GMHA to disseminate information on the MHA was repeatedly identified as a barrier to increasing public awareness of the MHA:

> *"Awareness of the existence of the MHA is low. This is due to a lack of resources for the GMHA to embark on vigorous public sensitisation about the MHA. We need to do more on this as a society to stand any chance of implementing the MHA."*
>
> (IDI_#03, NGO)

Both a senior health administrator and a local Government inspector echoed other participants' concerns about the low penetration of the MHA. It was considered that public awareness of the MHA could be raised by media agencies reporting on mental health initiatives:

> *"Yeah, public education and sensitisation about the MHA are low; many people are not accessing mental health services because of ignorance about the law. We need to have our FM and TV stations talking about mental health to create awareness."*
>
> (IDI, Municipal Health Insurance Authority)

Similarly, a senior mental health administrator also commented on the poor understanding of the MHA among the public, including mental health service providers. He added there was a need for authorities to do more to increase public knowledge through funded campaigns:

> *"We have not done very much along the line of awareness creation, we need to sensitise the public, yes awareness has increased about mental health for both persons with or without mental illness, but it has not gone to the appreciable extent that we want. Our records show*

that even mental health service providers have little awareness of the MHA. So, a lot of public education needs to be done to improve awareness about the MHA."

(IDI, Senior Mental Health Administrator)

A District Magistrate described the lack of knowledge of the MHA as being common in Ghana stating that public awareness of legal matters is generally poor, and many laws are not implemented:

"Not at all. In my experience, people are not aware of this MHA. Most of Ghana's laws are not implemented and not known to the people, including this Act."

(IDI, District Magistrate)

A community mental health officer considered that the introduction of the MHA had not achieved the anticipated progress. Public awareness of the MHA was low, and this included many health professionals:

"There is not much progress; I will say even mental health professionals do not know much about the MHA and its free mental health services provisions. Health practitioners do not have the resources to reach out to community with mental health programs."

(IDI, Community Mental Health Officer)

The NCCE is an independent, non-partisan Governance institution established under Article 231 of the Republic of Ghana's Constitution. The NCCE is not sufficiently resourced to carry out its mandate to educate the public about their rights and responsibilities. In discussing the responsibility of the NCCE to ensure that people understand their rights and responsibilities under the MHA, a District Magistrate summarised:

"The NCCE will tell you there are no resources to educate the public about mental health and people's rights."

(IDI, District Magistrate)

Mental health service providers commented that only a few people living with mental health disorders would be aware of the existence of the MHA. Those having such awareness will likely be educated and living in cities and urban centres. However, the majority of these patients, including service providers, are not aware of the MHA, which is a challenge to implementation:

"Some health workers are not even aware of the existence of the MHA not to talk about people living with mental disorders. Naturally, people cannot demand something they are unaware of."

(IDI, Medical Superintendent, Municipal Hospital)

In contrast, an NGO participant stated that people are aware of the existence of the MHA; however, due to illiteracy, they may not be aware of the detailed requirements, duties and responsibilities stipulated in the MHA:

> *"Some people are aware of the existence of the MHA. However, the details of the MHA may not be very obvious to them. Clearly, for reasons of literacy, for reasons of translations and the rest. However, many people will be unable to read the MHA in its entirety and understand it."*

(IDI_#01, NGO)

Some participants blamed mental health leaders for not doing enough regarding information dissemination. For these participants, those charged with direct implementation of the MHA have not been appropriately informed of policy directions as the flow of information has been lacking at all levels, from operational executive to frontline clinical staff:

> *"Yeah, communication and information flow are essential. The senior operational officers, such as the psychiatrists, should ensure that they communicate effectively with the frontline staff to enhance the services rendered to patients. Most of the time, those at the District level do not get to know what is going on regarding mental health, which impedes the implementation of the policy."*

(IDI, Clinical Psychiatric Officer)

Another participant expressed the view that failure to provide online access to mental health policy documents was a reason for limited publicity of the MHA, placing the blame squarely on the policymakers:

> *"The MHA has not come as an application on the internet, just as we have Ghana's Constitution. We have our various social media platforms for health professionals, we have not seen this Act on any platform. So, on a thousand occasions, I will blame the GMHA and policymakers that they have relented their efforts so much that mental health needs resuscitation."*

(FGD_#01, Community Psychiatric Nurse)

Mental health service users and their carers expressed their opinion about the lack of awareness of the MHA due to poor dissemination. Commenting on the MHA penetration among relevant key stakeholders, a mental health service user acknowledged his lack of knowledge of the MHA and called for efforts from mental health authorities to raise awareness among people living with mental illness:

> *"I do not have any idea about the law. The mental health authorities should go to the grassroots and educate those who have mental illness about the law. They should go to their doorstep and educate all of them about their rights and responsibilities."*
>
> (IDI, Mental health service user)

A mental health service user and a carer expressed frustration with what they described as Government rhetoric and lack of action in ensuring that mental health services are available for those who need them. These participants who were sceptical about the willingness of Government to support people needing mental healthcare also appealed to the researchers to advocate for Government support in improving access to mental health services:

> *"Government only makes promises when they are around us. We do not hear anything from them once they leave. As you are part of those in mental health, add your voices to the need for the Government to support us. You have to speak about it so that the Government can support us; otherwise, things would not get better."*
>
> (FGD_#02, Carer of a Mental Health Service User)

> *"The Government claimed to be protecting us, yet we do not see it; protection should not be by word of mouth only but also through action. The Government has to take action before things can get better."*
>
> (FGD_#01, Mental Health Service User)

Participants considered that the MHA had not been adequately disseminated to the public, affecting the general mental health service provision as people cannot advocate for their rights as stipulated in the MHA. Some mental health service providers were not aware of the existence of the MHA. Mental health services users and carers appeared to have little or no knowledge of the MHA. Policymakers believed that there is a need for the public to demand more from the central Government to prioritise mental healthcare.

7.10 Mental health stigma and discrimination

Stigma and discrimination have been identified as one of the most important issues for mental health reform nationally (Barke et al., 2011; Edwards, 2014; Mfaofo-M'Carthy & Grishow, 2017; Ofori-Atta et al., 2018; Walker & Osei, 2017) and internationally (Badu et al., 2018; Kohrt et al., 2020; Krendl & Pescosolido, 2020; Stangl et al., 2019; Whiteford et al., 2013). One of the issues raised by the study participants as indirectly responsible for the slow implementation of the MHA was stigma and discrimination against people with mental illness. Some participants considered that stigma and false accusations against people with mental illness were widespread and extended to primary carers. Carers have been accused of causing their relative's mental illness by involving themselves in money rituals (local sacrifices to gods to

get wealth or favour), stealing or other wrongdoings in the past, bringing the sickness onto their relatives as a form of punishment. These negative attitudes towards people living with mental illness and their carers have prevented some people from disclosing their health conditions or even seeking treatment at a health facility. There is a need to protect the rights of people living with mental illness; thus, the MHA has had a limited impact in addressing these concerns.

Some mental health service providers discussed the prevalence of stigma and discrimination in Ghana, and the negative impact on the implementation of the MHA. It was felt that stigma and discrimination prevent people living with mental ill-health from seeking help at health facilities:

> *"Stigma and discrimination remain an indirect challenge to implementation. People still find it challenging to come to the mental health units for treatment because they would be stigmatised."*
>
> (FGD_#02, Community Psychiatric Nurse)

A senior RMHC indicated that the stigma and discrimination attached to mental illness make it difficult for major stakeholders to pay attention to mental health:

> *"Having dealt with many stakeholders before the passage of the MHA, I think that stigma and discrimination attributed to mental illness making it very difficult for these major stakeholders to turn their attention to mental health. So, I think stigma is a significant challenge to implementation."*
>
> (IDI_#09, RMHC)

Secondary or associative stigma is often experienced by family members of people who suffer from mental illness or attached to those who care for people living with mental illness through their professional roles (Kuntanaah, 2018; Olagundoye et al., 2017; Waddell et al., 2020). A representative of an NGO thought that people working in the mental health sector face stigma similarly to mental health service users, especially at the district level. Many people continue to think mental health is not part of mainstream health provision. Decentralisation of mental health services as envisaged in the provisions of the MHA have not yet been put into effect:

> *"Again, what we see at the district level is that people working in mental health services face a lot of stigma. People do not think that we belong to the mainstream health service provision; there is a stigma attached to people with a mental health condition. We still have people travelling from the North to the South to seek mental healthcare, which is not supposed to be the case. So, decentralisation has not been effectively put in place."*
>
> (IDI_#03, NGO)

The MHA was legislated to create a modern community-based mental health system to protect the rights of persons with mental illness. The juxtaposition of this Act and a culture that still links mental illness to animistic and traditional beliefs pose important implementation challenges. Some participants expressed the view that it may be pointless wanting to fight stigma. It was felt that while the mental illness remained, stigma and discrimination would persist. For some in the community, mental illness was attributed to witchcraft. Mental health service users and carers discussed the impact of stigma and discrimination as a barrier for seeking mental health services. These participants felt that the rights of people living will mental ill-health had been violated by others and that the Government ought to protect and support people living with mental illness through full implementation of the MHA:

> *"Sometimes people say that maybe a relative of the service user had stolen or done something wrong hence the punishment manifested in the mental illness, or it is because a relative of the service user had engaged in some money rituals and now facing the consequences. People make many false accusations that stigmatise mental illness a lot and make it difficult for those suffering to seek treatment freely."*
>
> (FGD_#02, Carer of a Mental Health Service User)

> *"Mental illness is associated with stigma and discrimination. Some people attribute the causes of mental illness to a person's mother destroying her own child life with witchcraft. People will be avoiding the patient and asking them to send their mother's witchcraft away."*
>
> (FGD_#01, Mental Health Service User)

For some participants, stigma and discrimination against people living with mental illness can contribute to the condition. One participant recounted how her close neighbour's attitude and behaviour contributed to a relapse of her relative's condition:

> *"Some time ago, my child picked a dead duck outside and brought it home. He brought it home for us to prepare a meal for him. All the neighbours in the house started laughing at him until we all became very uncomfortable. My child condition started deteriorating because of that experience."*
>
> (FGD_#04, Carer of a Mental Health Service User)

Social prejudice and avoidance of people with mental health issues can also emanate from within social groups viewed within the Ghanaian culture as morally obliged to support the individual. Sometimes the discrimination and negative attitudes towards people living with mental illness are perpetuated by close neighbours and affecting help-seeking for mental illness. A carer and a service user commented on how stigma can make people depressed:

> *"For my child, people started calling him names. Even children in our neighbourhood call him by some funny names. Sometimes, when I come for medicine, other people make humiliating*

comments. Sometimes people closer to us will say things that are embarrassing and humiliating."

(FGD_#3, Carer of a Mental Health Service User)

"Many people said a lot of negative things to me. Sometimes, when you offend someone, the things they will say to you will make you cry. When you go to people house, they will refer to you as a dirty and mad person. You become sad, and you cry a lot during those times."

(FGD_#06, Mental Health Service User)

A carer described the difficulties of renting and staying in rented accommodation when a person has mental ill-health. Landlords or house owners do not want to rent houses to people with such conditions; if a landlord realises a tenant has mental ill-health, they will be asked to move out of the property. This participant narrated the ordeal faced when a landlord discovered that her daughter has a mental illness:

"Since my daughter's sickness begun, we have been renting rooms. Even one of the house owners proposed to marry my daughter, and she refused because she was schooling. When she later got the sickness, the house owner asked us to leave his house because of the condition, and we have to comply. So, we have gone through a lot. So, for those of us renting houses, we are always in trouble."

(FGD_#07, Carer of a Mental Health Service User)

A number of stakeholders made suggestions to mitigate the impact of stigma and discrimination. Participants commented that people with mental ill-health should be treated with dignity and respect; they should be provided with adequate psychotropic medication to mitigate treatment relapse; they should be supported to feel they belong in society. It was thought that this would support healing:

"In my house, I do not discuss any issue with anyone apart from those I stay with, that I sometimes play with them. When I wake up, I go to work and come back after work."

(FGD_#01, Mental Health Service User)

Another participant concurred over this problem, explaining that maintaining a consistent supply of psychotropic medication was important to avoid stigma and discrimination due to treatment failure. A carer of a mental health service user remarked:

"It is the medicine that would help us to get healing and avoid stigma and discrimination. The Government should ensure a constant supply of medicine for us."

(FGD_#07, Carer of a Mental Health Service User)

However, a key policymaker was of the view that stigma and discrimination against people with mental illness have declined as a result of the introduction of the MHA, even though this reduction is yet to be measured:

> *"Since the introduction of the MHA, stigma has reduced but not significantly to the point that we all want. What we need to do is to let it go down further and also to measure the decline."*
>
> (IDI, Senior Mental Health Administrator)

Participants discussed stigma and discrimination as indirectly affecting mental health service provision and impeding the implementation of the MHA. Participants discussed that stigma and discrimination was widespread and advocated for Government intervention to minimise it. While a key policymaker thought stigma had declined since the introduction of the MHA, mental health service providers, users and carers had contrary views, indicating that stigma against people living with mental illness remains pervasive and affects help-seeking as well as access to mental health services.

7.11 Mental health literacy and empowerment

Lack of empowerment of people with mental illness to take more personal responsibility for the healing process was identified as a barrier to implementing the MHA. Mental health literacy was introduced in 1997 and was described as knowledge and understanding about mental disorders. It was introduced to aid recognition, management and prevention of mental ill-health (Jorm et al., 1997). People with limited mental health literacy may be unable to recognise signs of distress in themselves or others, which can stop them from seeking support. As reported (see section 6.7), a lack of understanding about mental health amongst the general public contributes significantly to discrimination and stigma toward those living with mental ill-health (Jorm et al., 2006)

Mental health literacy is an important empowerment tool that helps people manage their mental health. Policymakers and implementers considered inadequate knowledge of mental illness and treatment sources to impede access to mental healthcare. Lack of mental health knowledge was described by a senior member of the NCCE and a representative of an NGO as widespread in Ghana, including senior Government officials and policymakers; this view was thought to affect the management and allocation of mental healthcare resources. The participant added that mental health experts need to be involved in high-level governance to promote mental health:

> *"At senior levels of Government, they need somebody who understands mental health and the MHA. Many senior officials lack knowledge of mental health and do not even think they need to give mental health authorities resources to work. So, we need those who have mental*

health knowledge to get to the highest level of governance to promote mental health. If they know the magnitude of this problem, they will be ready to respond appropriately."

(IDI, NCCE)

"Right from the Governmental level, the Minister does not think that mental health is worth investing in because he is likely to be one who thinks that mental illness is a curse, mental illness can only be managed through spiritual beings and not through medicine or hospitals, so why put money in that? So, that is the main challenge affecting the mental healthcare system in Ghana."

(IDI_#01, NGO)

Another senior mental health administrator maintained that low mental health literacy among the population, coupled with a lack of integration of mental health services into primary healthcare, remains a challenge for mental healthcare in Ghana:

"Mental health literacy is another challenge, and integration of mental healthcare into general healthcare and equitable spread of quality mental healthcare."

(IDI, Senior Mental Health Administrator)

A representative of the CHRAJ suggested that public education about mental health should be used to improve mental health literacy among the population. Resources should be made available for mental health professionals to educate people about mental health through community outreach programs and the mass media. These participants commented that many people, including those with high educational attainment, lack knowledge about mental health as some people were resorting to TFHs for relatives with mental ill-health:

"There was a young man who came to my office, and when I invited his father, we got to know that the young man was suffering from a mental health condition. The father was relying solely on traditional herbs for treatment. I discussed with the father about the law and the appropriate places that they could visit for treatment. The father of this young man who had the mental health condition is an educationist and a sub-chief in one community. So, ignorance about mental illness is a key barrier to implementation."

(IDI, CHRAJ)

Low mental health literacy was a theme frequently mentioned by participants in the mental health service providers group. Many people living with mental illness remain disempowered due to their limited mental health literacy. Community psychiatric nurses stated that people with mental illness are not assertive enough to access information about their condition, affecting how they manage it. They reported:

"Mental health service users do not find out more about their condition to understand what they are supposed to do and what they are not supposed to do. When you tell patients what they are not to do, they generally follow your guidance."

(FGD_#04, Community Psychiatric Nurse)

> *"People with mental illness lack knowledge about the MHA, especially those residing in rural and deprived areas."*

(FGD_#02, Community Psychiatric Nurse)

Lack of mental health literacy is an indirect barrier to seeking treatment for mental illness. An RMHC observed that people's beliefs influence how and where they seek help. According to this participant, creating awareness is critical in improving help-seeking at mental health facilities:

> *"There are other times people have come to me after they have been to spiritual healing centres for months without any progress. These patients later come to access our services; after 2 – 3 weeks, they see improvement and confessed that they would have used our facility as the first point of call if they knew the conventional health facilities could cure their ailments."*

(IDI_#07, RMHC)

Another participant indicated that cultural belief systems that negatively impact mental healthcare could be modified through education, which unfortunately is currently not being promoted by the Government:

> *"For cultural beliefs, education will mitigate the misconception, but the main problem is the authorities' lack of effort to ensure mental health education. The Government has not empowered the mental health staff to disseminate mental health information to people living with mental illness and the general public."*

(FGD_#03, Community Psychiatric Nurse)

However, an RMHC stated that mental health literacy is gradually increasing in Ghana because of the measures put in place by the GMHA and other agencies to promote mental health. He stated:

> *"Mental health literacy in Ghana is now picking up; some years ago, it was on the low, but currently, there is an aggressive move by the GMHA and other stakeholders to improve mental health literacy."*

(IDI_#05, RMHC)

Mental health literacy is essential as it contributes to people's help-seeking behaviour and subsequent mental health outcomes. Participants viewed the lack of understanding of mental health among the general population, including people with higher educational attainment, as

a barrier affecting the implementation of the MHA. Mental health service users and carers did not discuss mental health literacy as a challenge to the implementation of the MHA.

7.12 Mental ill-health and poverty

Mental ill-health and poverty interact in a negative cycle in low- and middle-income countries (Ae-Ngibise, Doku, et al., 2015; Lund et al., 2011). Poverty and economic hardship has been found in some cases to be a precursor to mental illness (Chidarikire et al., 2020). Participants identified poverty as a demand factor contributing to people not seeking treatment from conventional health facilities for mental illness. Arguably, people living with mental illness do not have the required resources to travel long distances to access treatment at the few tertiary psychiatric facilities located in the Southern parts of Ghana.

Mental health service providers discussed poverty as a barrier to accessing mental health services. One community mental health nurse stated that people with mental illness are currently made to pay before being admitted into the health facility. This negatively affects people seeking admission, especially those in the rural areas who cannot afford admission charges:

> *"Currently, before a patient is admitted, he or she has to pay some fees. What about patients who cannot pay? So, those who cannot pay or those who are poor, those in the rural areas, will continue to lack the knowledge about mental health or stay away from the facilities because they cannot afford the fees. The health authorities are also not providing staff with the required logistics to reach out to people with mental illness in their homes."*
>
> (FGD_#02, Community Psychiatric Nurse)

Some mental health service users cannot afford the cost of medication resulting in treatment relapse. An RMHC commented that there had not been significant progress with implementing the MHA because some patients could not procure medication due to poverty, and the Government was not consistent in supplying these medicines following the free mental healthcare policy. These were hindering the implementation of the MHA:

> *"We have not seen any significant progress in implementing the MHA. Over the years, we have understood that mental health services are free, but we do not have the medication for patients. When patients come, and we prescribe medication for them to buy, some do not have the money to buy the medications, resulting in treatment relapse."*
>
> (IDI_#06, RMHC)

Mental health service providers indicated that referrals of people with mental illness from the districts to the tertiary level are sometimes not completed due to poverty:

> *"Referrals usually do not go through due to poverty. Sometimes you see a client, and it demands that you refer the person to the tertiary facility, and they would tell you that, for Kumasi or Accra, I cannot go because of lack of money for transportation. So, poverty becomes a challenging factor."*
>
> (FGD_#01, Community Psychiatric Nurse)

Since some people with mental illness cannot afford the cost of treatment at the tertiary psychiatric healthcare level, they resort to traditional and faith-based healing centres which are more affordable or free:

> *"The first thing that influences some people to seek treatment at faith-based camps is because of affordability. At that place, there is no cost component; you go, you are accommodated, you feed yourself, and when you get healed, you return and compensate the healer."*
>
> (IDI_#09, RMHC)

A TFH indicated that the services he provides to people with mental illness are free of charge, but people can return voluntarily to the prayer camp with a gift to thank God for healing them. Although mental healthcare is supposed to be free by law, the associated cost of treatment at the conventional health facilities acts as a barrier to help-seeking:

> *"The services I offer are free. I do not demand money. If, by God's grace, a patient receives healing, such a person can bring anything willingly to thank God for the healing mercy."*
>
> (IDI, Faith-Based Healer)

People with mental illness and their carers continue to utilise the services of TFHs because of poverty. However, inhumane practices, including chaining of agitated patients, continue to be widespread in the prayer centres. The position taken by this TFH regarding chaining people with mental illness suggests a lack of knowledge about the statutory provisions of the MHA. It might also imply an unwillingness of TFHs to accept the humane rights stipulations of the MHA:

> *"Most people with mental illness are poor and cannot afford the cost of medical treatment at the hospitals unless at our places. We will still chain them because we have no other means of restraining aggressive patients at our place."*
>
> (IDI, Community Traditional Healer)

Comments such as this from the TFH above highlight the need for the GMHA to intensify targeted public education about the MHA and what it stands for. Such education will help in promoting and facilitating the implementation of the MHA.

7.13 Chapter summary

This chapter has reported findings on barriers impeding the implementation of the MHA as identified and discussed by mental health sector stakeholders in Ghana. The passage of the MHA in 2012, which has been recognised locally and internationally as an important initiative for improving mental health services, has been met with slow implementation.

There was a general concern about the lack of progress in implementing the MHA that was echoed by participants to the effect that there have been limited achievements following the introduction of the MHA because of the lack of commitment, especially political leadership towards implementation. Participants identified the following 8 barriers to timely implementation of the MHA: 1) inadequacy funding, 2) lack of political commitment and leadership 3) failure to pass the required LI to provide the framework for implementation 4) insufficient mental health professionals 5) lack of advocacy and community awareness of mental health 6) negative effects of stigma and discrimination 7) competing cultural belief systems and indigenous practices and 8) low levels of mental health literacy. Funding inadequacy and lack of political commitment and leadership were the most frequently identified barriers to implementing the MHA.

While policymakers and community opinion leaders discussed long-term barriers to implementing the MHA, mental health service providers, users, and carers were more concerned about the unavailability of the day-to-day logistics for mental healthcare. Mental health service users and carers struggled to identify some obstacles to implementation, but were quite clear about the link between poverty and mental illness acting as an indirect barrier to mental health service implementation.

There was a consensus amongst stakeholders that public knowledge of the MHA statutory requirements was low due to insufficient support for the provision of mental health promotion activities. It was considered that reliance on conventional media such as television and radio had largely failed to get key mental health reform messages across to the community. It was also felt that low literacy levels among certain sections of the Ghanaian society had contributed to the very limited public dissemination of information on the MHA. There was a widely held view among participants that Government and public sector authorities ought to provide the support necessary to raise public awareness of the MHA's provisions. This lack of mental health literacy holds back the potential for more widespread advocacy in support of the implementation of the MHA among the public and especially from service users and carers. Largely extent, mental health service users and carers were unaware of the existence of the MHA.

In particular, a number of participants pointed to the need for reliable transport for outreach activities targeting patients, carers, and community groups. Of most concern at the time of writing this Thesis eight years following the MHA establishment, some key stakeholders - mental health service providers, policymakers, Government officials, and community opinion leaders, continued to be poorly informed regarding the legislative detail of the MHA.

Participants suggested an increase in Government funding for mental health services and concerted public mental health education to mitigate negative cultural beliefs and practices affecting mental health. Improvement in mental health literacy was also among the suggested measures to speed the implementation of the MHA. Chapter 8 presents the findings concerning the role of TFHs in providing mental health services.

Chapter 8 Role of Traditional and Faith-based Healers in implementing the MHA

8.1 Introduction

This chapter presents the role of TFHs in mental healthcare, as reported by the key stakeholders presented on Table 12. The chapter begins with an overview of help-seeking practices for people living with mental illness and the factors influencing a particular treatment option. This is followed by a discussion about the role and relevance of TFHs in providing mental health services from both key stakeholders' and service users' perspectives. The need for collaboration between conventional mental health services and TFHs and mental health service users' and carers' experiences about their past encounters with TFHs is then presented. The chapter concludes with a summary discussion about the relevance of TFHs and recommendations for future governance including options for regulating the practice of TFHs to increase their accountability and the elimination of human rights violations, in the context of a sustainable mental healthcare system in Ghana.

8.2 Theoretical background of help-seeking behaviours

Health workforce is an important consideration in health policy research in Africa and elsewhere globally. TFHs are reportedly patronised by people living with mental illness in countries such as the Middle East or Asia, Latin America and the Caribbean. Whether these TFHs sit inside or remain outside of conventional mental healthcare systems is a fundamental issue that requires further critical assessment.

In Ghanaian context, TFHs refer to both church pastors and indigenous fetish priests, both groups being viewed as TFHs. Pastors are ordained leaders of a Christian congregation and provide leadership to the members of a church. Pastors in the prayer camps are viewed as an extension of recognised religions, with many being answerable to a religious hierarchy such as within the Pentecostal Church. Prayer is an integral part of seeking divine healing from God. On the other hand, fetish priests are Sharman, serving as mediators between the spirits and the living, worshipping their Gods through enclosed places called shrines (Palmer, 2010). The priest or priestess performs rituals to consult and seek favour from the Gods in the shrine. Sometimes the rituals are performed with animals, money, liquor, and other items deemed necessary for the ritual. The fetish priest, unlike the pastor, is usually chosen through divination

or spiritual nomination of the shrine (Briggs & Connolly, 2016). Believed to help people in spiritual matters and physical needs, fetish priests are feared because they claim that they can kill people spiritually and heal people, including those with mental ill-health. People still attend fetish priest's shrines for treatment of mental illness.

As with many developing countries, indigenous and faith-based healing has been the cornerstone of healthcare in Ghana for generations (Ae-Ngibise et al., 2010; Akol et al., 2018). From the perspective of many Ghanaians, the attribution of mental illness and consequent help-seeking behaviour continues to be heavily influenced by traditional animistic and religious beliefs. Some people living with mental health disorders and their primary carers seek help from prayer camps operated by TFHs because of their cultural beliefs concerning the aetiology of mental disorders, which is commonly grounded in retribution, spirituality and other economic and social factors such as cost and access to health facilities (Anyinam, 1989; Osafo, 2016; Read, 2012). TFHs, therefore, play a significant role in mental healthcare, notwithstanding reported human rights abuses such as chaining or beatings to exorcise evil spirits (Ssengooba et al., 2012). A survey by the US Agency for International Development indicated that in sub-Saharan Africa, indigenous TFHs outnumbered bio medically trained health practitioners by a ratio of 100:1 (World Health Organisation, 2002).

Transformative pressure asserted through the introduction of the MHA will likely be met with resistance if there is continued failure to adequately educate all stakeholders on their respective responsibilities under the new legislation.

The MHA has made provision for collaboration between TFHs and conventional mental health service providers. The GMHA has produced guidelines for regulating the practice of TFHs. Nonetheless, after these additional interventions, there are still key issues militating against tapping into this strategic partnership to implement the MHA. The resistance to some degree is grounded in the argument of what is and what is not scientific. Bio medically trained clinicians including doctors, nurses, psychologists, social workers and other allied health professions consider their diagnostic and treatment decisions to be 'evidenced-based' and therefore scientific. This shared perspective manifests as scepticism of the benefit of scientifically unproven traditional and faith-based treatments for the treatment of mental health disorders (Incayawar et al., 2009). A further barrier to the acknowledgement of the role of TFHs is the contrasting notion of disease aetiology. Whereas the biomedical perspective restricts aetiology of disease to the natural world, African, including Ghanaian, pluralistic traditional medicine frames disease within a broader category encompassing the natural, supernatural and social worlds (Baronov, 2010).

Participants discussed the role of TFHs as a potential barrier to implementing the MHA. TFHs remain relevant to mental healthcare because a high percentage of Ghanaians and people from other African countries are of the firm belief that spirits cause mental illness (Drury, 2020; Kpobi & Swartz, 2019). Therefore, people with mental illness and their families will seek spiritual treatment, including herbalism and faith-based practices as curative measures (Ae-Ngibise et al., 2010; Opare-Henaku & Utsey, 2017; Patel, 2011). Other participants considered that human rights abuses by TFHs were frequently reported and would continue as there were no means of restraining people with mental ill-health who were aggressive and agitated at traditional and faith-based treatment camps. Although some NGOs and the GMHA have been providing training for TFHs, some TFHSs still do not accept that forcefully restraining or chaining a person with mental ill-health violates their fundamental rights.

8.3 Role and relevance of TFHs

It is widely held that TFHs play an important role in mental healthcare in Africa and other developing countries (Ojagbemi & Gureje, 2020). Participants in the current study considered that TFHs play an essential role in treating people with mental illness in Ghana. Incayawar et al. (2009), estimate that 85 per cent of the world's population relies on traditional healers and medicines to meet their healthcare needs. However, the participants also identified some human rights violations perpetrated by these practitioners in the performance of their role that need to be addressed for successful implementation of the MHA. Participants argued that these practitioners must be regulated and incorporated into the mental health services system to improve the help provided to those who always have and are likely to continue going to TFHs for mental health assistance. In discussing the role of TFHs in mental healthcare and implications for implementing the MHA, three themes emerged, that is cultural construction of mental illness, accessibility and proximity of TFHs and cost of treatment for mental illness. These three themes identified by the participants are explored in detail.

8.4 Cultural construction of mental illness

Many participants felt entrenched cultural belief systems and practices were likely to impede the effective implementation of the MHA and overall mental healthcare. Mental disorders continue to be widely perceived as being caused by spiritual forces rather than natural causes in most African countries (Chidarikire et al., 2020). Thus, people with mental illness continue to access faith-based centres for healing, with reports of ongoing human rights abuses (Ae-Ngibise et al., 2010). Unfortunately, today, many traditional and faith-based healing practices are considered a gross violation of the individual's human rights under the new mental health legislation and, are therefore, illegal. Notwithstanding this, many of the practices have been

embedded and accepted in the Ghanaian culture for generations. It was reported by participants that many TFHs did not realise that chaining people with mental illness was abusive and violated their rights as stipulated in the MHA.

Policymakers considered that TFHs play an important role in mental healthcare, albeit with a held misconception about the causes of mental illness. Some participants pointed out that apart from people attributing the causes of mental illness to spiritual forces, some also believed that a person with mental illness could not recover fully, making it challenging to seek conventional healthcare. A senior local Government administrator stated:

> *"Apart from the fact that our people say mental illness cannot be fully cured, some people, especially in rural communities, associate it with a spiritual thing, they associate mental illness to spirits, so it would be challenging to convince them to seek at the treatment hospital."*
>
> (IDI, Local Government Inspector)

This was an observation from a member of Parliament who amplified the role of spirituality in seeking care for mental health:

> *"In Ghana, we associate most mental health conditions with spiritual connotations because of our faith. Many people with mental ill-health frequent pastors, mallams, and traditional healers for healing. So, if we do not include these practitioners in our strategies as far as mental healthcare is concerned, we will lose a lot of the people in those camps. In that case, I think TFHs are very strategic and vital to every strategy or action taken towards holistic mental health delivery."*
>
> (IDI_#01, Member of Parliament, Ghana)

An RMHC further pointed to the complex nature of African pluralistic medicine, incorporating supernatural and religious constructs that are very much at odds with western biomedicine. She considered the services of TFHs relevant to mental healthcare management because of the African belief system. In line with what has previously been reported (Ae-Ngibise, S. Cooper, E. Adiibokah, B. Akpalu, C. Lund, V. Doku, & Consortium Mhapp Research Programme, 2010), this participant commented that regardless of more comprehensive mental health reforms, people with mental health problems and their families will continue to seek help from TFHs:

> *"Yes, they are relevant. Looking at the cultural background, we are Africans, and then we believe in supernatural beings, right? So, most people have their beliefs, and then they have the right to their beliefs. When people experience certain symptoms or break down with certain mental conditions, trust me, the first place some people will visit will be the prayer camps; they will go to see a traditionalist or spiritual person. So, what we can do instead, is to collaborate with these healers through sensitisation to minimise the abuse of patients under their care."*

(IDI_#04, RMHC)

People with mental health problems will go to TFHs because of the perception about the causes of mental illness, which some people attribute to spiritual forces that require spiritualists to heal them. RMHCs considered that since patients cannot be prevented from seeking the services of TFHs, it is best to collaborate with them and train them to understand what they are able and not able to do:

> *"Very well, the services of TFHs are relevant because the majority of our patients still access treatment over there, and we cannot entirely close or prevent them from rendering these services. The way forward is to collaborate with them and modify their practices, not to incur human rights abuses."*

(IDI_#09, RMHC)

Similarly, a Municipal Director of Health Services indicated that some people with mental illness believed in the healing power of TFHs due to their cultural belief system; therefore, there is a need for collaboration with these practitioners:

> *"TFHs are relevant because of our cultural beliefs system. So, you cannot tell patients not to go to these healers when their faith tells them they will get healed from these healers. We are collaborating with these unorthodox health practitioners."*

(IDI, Municipal Director of Health Services)

A participant from the MoF also stated that TFHs are essential in mental healthcare, not only in Ghana but the entire African continent:

> *"TFHs are significant players in mental healthcare because of our belief systems not only in Ghana but the whole of Africa. We had a meeting last week involving participants from Sierra Leone, Liberia, Nigeria, and Uganda. Most participants in this meeting discussed that when people suffer mental illness, they always see the spiritualist or the traditionalist first when the condition is not getting better. They will move to the pastor as the next line of treatment. So, the spiritualist or the pastor is mostly the first point of call for most people with mental illness in Africa."*

(IDI, Financial Sector Administrator, MoF)

Contributing to the reasons people with mental illness seek help from TFHs, a senior mental health administrator suggested the strength of religious enculturation in Ghana heavily influences individual explanatory models of ill-health and, in particular mental health. People do not thoroughly understand mental illness, and anything that people do not understand is linked to spirituality. He narrated the following:

> *"People will always seek help from the TFHs, and they go there primarily because of their belief system. By our nature, Ghanaians, are religious, which I am happy with, but we tend to take our religiosity to the superstitious dimension. Somebody wakes up in the morning, sneezes or stumbles, and immediately link it to spiritual issues; either an auntie, uncle or someone is bewitching him or her. Mental illness is an area that often people do not understand, so they quickly link it to spirituality and therefore have to visit the spiritualist for answers."*
>
> (IDI, Senior Mental Health Administrator)

The MHA recognises the services of TFHs (Act 846, 2012, section 3) in the management of people with mental ill-health. There is a need for stricter supervision at faith-based camps to regulate and monitor ongoing activities to minimise or prevent human rights abuse. Collaboration is key in preventing violation of patients' rights in the faith-based camps:

> *"Yes, TFHs are very relevant. Culturally, people seek mental ill-health treatment from conventional health facilities and still go for spiritual intervention. So, people seek help from the two systems simultaneously, such that we cannot do without TFHs. We have to incorporate them into mainstream mental healthcare."*
>
> (IDI_#03, RMHC)

A medical superintendent stated that traditional and faith-based healing has a role in mental healthcare and should be used alongside conventional healthcare:

> *"I believe that there is a place for both orthodox and unorthodox medicine to care for people with mental illness. My advocacy is for people not to stop taking their medication just because they have seen a pastor or someone who believes that they can spiritually cure their illness. Faith-based or traditional healing is documented, so I have no evidence that it does not work, but I think it should be used concurrently with orthodox medicine."*
>
> (IDI, Medical Superintendent, Municipal Hospital)

TFHs also discussed their relevance in mental healthcare. From a Ghanaian perspective, what distinguishes traditional healing from biomedicine is the strong emphasis on spiritual healing as an inseparable component of all recovery, including mental health. In defence of their practice, some TFHs argued that there are a number of diseases that cannot be cured by biomedicine alone, hence the critical role of TFHs. Spiritual healing involving prayers and herbal treatment was considered very relevant for treating mental illness, as reported by a TFH who participated in this study. According to this healer, there are some diseases that western medicine cannot cure, but spiritual healing can, through prayers and fasting. He added that no patient has ever died in his prayer camp:

> *"Dealing with mental illness spiritually is extremely helpful. It is beneficial because there are certain sicknesses where you will take medication several times and not get better. So, spiritual healing is very good. Those of us who do not use western medicine know that it helps a lot. No one has ever died in my prayer centre."*
>
> (IDI, Church Pastor)

In sharing his experiences of treatment outcomes, a Muslim healer stated that he had cured patients who have been to several places searching for healing before coming to his home, stressing that he believes it is always God's will to cure or not to cure the ailment of a person. He considered that the services provided by TFHs are relevant to people living with mental illness:

> *"Many times, people who have come here always said that they had been everywhere, hospitals, fetish priests, and not getting well. I always tell them to calm down because I am not doing it, God is doing it, and God is the most powerful of all the beings; If it is God's will that you are cured, you will be, if not his will, so be it. TFHs are very important in mental healthcare because we can cure people suffering from mental ill-health."*
>
> (IDI, Muslim Healer)

Concerning a specific role that TFHs can play within the mental healthcare reforms, a Municipal Health Director took a more optimistic position acknowledging that further integration between TFHs and conventional health services has been achieved. TFHs are gradually being recognised as providing liaison between health workers and the communities. There is a need to train these healers to prevent human rights abuses in the camps and shrines. This senior health administration added that TFHs who have been sensitised about mental illness and the need to respect the rights of patients were no longer chaining agitated patients admitted into their camps, as they had been encouraged to invite mental health nurses to assist whenever there was a need to do so:

> *"TFHs are being seen as the liaison officers between health workers and the community. TFHs who have been trained are no longer chaining patients. When they get an aggressive patient, they call the mental health nurse to come around and manage it while they continue providing spiritual treatment."*
>
> (IDI, Municipal Health Director)

The importance of providing holistic healthcare for patients and refining the clinical interface between TFHs and mental health services was further discussed by a senior policymaker, who pointed to the need for collaboration with the conventional health sector:

> *"Yes, people believe in TFHs, so we can only as an orthodox health team collaborate with these practitioners to provide patients' physical and psychological health needs. We need guidelines to ensure that human rights abuse is minimal in those unorthodox facilities."*
>
> (IDI, National Health Insurance Authority)

An RMHC indicated that the patient's spiritual concerns should also be considered alongside their physical concerns for holistic mental healthcare. Therefore, TFHs are relevant and should be regarded as partners in the mental health treatment pathway:

> *"Yes, TFHs are very relevant because they serve as our first line community mental health workers. We are superstitious, religious, and spiritual; so, we cannot disassociate ourselves from spiritual care. Even when you look at the provision of mental healthcare, the holistic approach, you cannot ignore the person's faith. Therefore, TFHs are partners and have helped manage patients despite reports of human rights violations."*
>
> (IDI_#05, RMHC)

TFHs have a role to play in the treatment of mental illness. Believing in a supreme being is thought to contribute to a good prognosis. However, given challenges with some TFHs abusing the rights of people with mental illness, a psychiatrist remarked:

> *"TFHs are relevant but with few challenges. Indeed, in practice, as part of the indicators for a good prognosis, we say that a belief in a higher force, be it God or whatever it is that the individual believes in as a way of faith, indicates a good prognosis. So, whatever it is, religion and the tradition of the people is important; however, one of the significant challenges we have had from the faith-based healing division of mental health service delivery is demonising mental illness and as a result, abusing the rights of persons with mental illness in the name of healing or curing or exorcism."*
>
> (IDI_#02, Psychiatrist)

Some people may seek the services of TFHs for reasons other than the belief system. Unprofessional attitudes by mental health professionals towards people with mental illness at the orthodox facilities may not accord well with patients' expectations. Health workers' attitudes to patients can determine help-seeking (Badu et al., 2018; Kapungwe et al., 2011; Osafo et al., 2012). A participant felt that when patients are not treated with an anticipated level of respect by health professionals, it is unlikely they will continue seeking help from health facilities:

> *"There is a certain kind of alienation, the kind of respect that patients think they deserve if not accorded at the hospitals; they may not feel inclined to come to the hospital next time they are unwell no matter how well you are a doctor or a nurse. So, they feel a certain sense of alienation when they come to orthodox facilities compared to when they go to TFHs."*
>
> (IDI, Senior Mental Health Administrator)

Within the cultural context of mental illness, social anxiety and psychological distress without persistent episodes may benefit from TFHs intervention. A senior mental health administrator remarked:

> *"Treatment outcome for minor mental illnesses such as mild or moderate anxiety, I will say, probably can be better handled by TFHs than in the hospitals. However, the major mental illnesses such as psychotic conditions, which are at the brain level, TFHs cannot handle them. So, I am saying that in short, it depends on the condition, and it depends on the extent to which this person has been able to capture the belief system so that they may respond better at the TFHs camps or the health facilities."*

(IDI, Senior Mental Health Administrator)

8.5 Accessibility and proximity of TFHs

Lack of access to mental health services was considered one of the reasons people relied on the services of TFHs. The majority of mental health facilities are currently located in the Southern part of Ghana (Akpalu et al., 2010). This geographical imbalance in resourcing between Northern and Southern Ghana will remain a barrier to implementing the MHA without resource redistribution or further capital investment, especially in deprived areas (Ofori-Atta, Read, Lund, et al., 2010). A legislator highlighted the resource imbalance and density of TFHs throughout the country:

> *"If traditional healers are seen to be very useful in treating mental illness, people will certainly go there. Moreover, you will note that all the mental health institutions are located in the southern part of Ghana; there is poor mental healthcare, so people have to rely on pastors and herbalists. We cannot do away with these traditional and faith-based healers because they are readily available, and patients and their families have more faith in these traditional institutions rather than orthodox mental healthcare, which is not available."*

(IDI_#02, Member of Parliament, Ghana)

TFHs live in the same communities as people with mental disorders; this proximity is an incentive for patients to access their services:

> *"The spiritualist, the traditional, and faith-based healers seem to be geographically, culturally, and socially closer to people living with mental illness than the conventional system. This proximity will also influence their help-seeking decision."*

(IDI, Senior Mental Health Administrator)

The services of TFHs are readily available in the communities, unlike conventional mental health services, which are few and ill-resourced, with medications being especially in short supply. A carer of a mental health service user suggested that to reduce patronage of TFHs by

service users, there is a need for consistent supply of psychotropic medication at the mental health facilities:

> *"The only challenge is that there are days you will come to the health facility for medicine but will be told there is none. This shortage of medicine makes some of us go back to the TFHs."*
>
> (FGD_#02, Carer of a Mental Health Service User)

A senior mental health administrator discussing the possible motivating factors that influence many members of the public to attend TFH services over conventional, suggested that fragmented bureaucracy acted as a disincentive to potential service users. People with mental illness also visit TFHs because they can obtain all the required services in these centres rather than deal with the conventional system's fragmented and heavily bureaucratised services. This participant observed that when accessing TFHs, patients and carers were not faced with the burdensome procedures found in mental health service facilities:

> *"When a patient visits the psychiatric hospital and sees the clinician in a coat with a stethoscope and instructing the patient to go through many rituals such as measuring blood pressure, temperature and making the patient uncomfortable. The clinician asks many questions, some of which are embarrassing, then gives the patient a prescription form to go to the laboratory for tests or the pharmacist, where the patient will queue for a long time before medication is supplied. So, this fragmented care becomes uncomfortable for people with mental illness."*
>
> (IDI, Senior Mental Health Administrator)

A representative of an NGO discussed the influence of TFHs in their respective communities and the role they play in the management of people living with mental illness. A number of participants agreed that the pluralistic nature of care provided by TFHs warranted recognition and a Director of an NGO asserted that collaboration with conventional mental health services was imperative to avoid abuse of patient's rights in the future:

> *"TFHs have influence in their communities, and their activities shape behaviours and attitudes. As a healer, if people see that you are not abusing them, and you provide proper treatment and accommodation, you can influence family members to do the same. If TFHs refer cases to conventional services, it will help avert chronicity. So, TFHs need to be seen and brought on board to understand their role in mental healthcare."*
>
> (IDI_#01, NGO)

8.6 Cost of treatment for mental illness

The cost of treatment for mental illness is a further driver for people seeking care from TFHs. Services offered by TFHs were considered more affordable by some participants compared to conventional mental health services. A pastor reported that the services he provides to people

with mental disorders were free and that some people would show appreciation through gifts or in-kind contribution. The excerpt below from the Pastor's interview further highlights the need for further education on rights and responsibilities under the MHA:

> *"The law is not very helpful because people come here to my camp seeking treatment, but I cannot admit them because of the law outlaws chaining. I have helped many people, and my name is becoming very well-known because of my work. Also, the services I offer are free. I do not demand money. If you receive healing by God's grace, you can bring anything from your heart to thank God."*
>
> (IDI, Pentecostal Pastor)

An RMHC corroborated the pastor's point regarding free services at some faith-based healing camps. This was considered a motivating factor for some people accessing healing from these faith-based practitioners, unlike the conventional or orthodox services where fees are charged for medications:

> *"I think the first thing that will make people seek unorthodox healing is its affordability. There is no cost component; you go, you are accommodated, you feed yourself, and you come and compensate the healer when you get healed. Unlike our place, the orthodox care, when you come, you are diagnosed and given a prescription to buy medicine."*
>
> (IDI_#09, RMHC)

A senior mental health administrator also added that cost of treatment at conventional health facilities and the flexibility of payment including through nonmonetary transactions at traditional and faith-based centres could be an important factor driving patients to seek treatment at the latter:

> *"People think that it is more expensive to go to orthodox facilities for treatment than traditional healers. The traditional healer can afford to say bring a fowl or chicken as payment for the treatment; even if you cannot bring it at that moment, you can go home and bring it later, and so again, the traditional or prayer healer can resonate well with them than the conventional system."*
>
> (IDI, Senior Mental Health Administrator)

A community opinion leader stressed the need for public education regarding free mental healthcare at conventional mental health facilities to encourage people to access services. According to the participant, people are sometimes worried about the cost of treatment in mental health facilities because they are unaware that the policy requires treatment for mental disorders to be provided free of charge:

> *"Many people are unaware that treatment for mental illness is free of charges. Usually, people are afraid of the cost involved, so we have to broaden our education to let people know that the treatment is free by law, everybody should participate, and they should avoid taking their relatives who have a mental health condition to the fetish priest."*
>
> (IDI, Community traditional leader)

8.7 Collaboration between conventional services and TFHs

Baronov (2010) argues that there has been an emergence of a mix of syncretic health beliefs and practices across African for some time that combine biomedical and pluralistic-elements, and that African pluralistic medical systems are dynamic and evolving. Notwithstanding this, this collaboration has predominantly focused on the treatment of physical illness as opposed to mental illness that requires a greater emphasis on traditions, values and cultural influences.

As a stakeholder group, mental health service providers generally considered that TFHs had a role in mental healthcare due to the firmly embedded belief in spiritual aetiology and natural explanations identifying phenomena and forces that cause illness. The majority of participants recommend a blending or dualism of systems in which TFHs are recognised but regulated under the MHA. Some participants in this group further argued a need to upskill TFHs to understand the limits of their involvement and appreciate the need to avoid abusing patients' rights through their practices. A clinical psychologist stated that it was possible for both orthodox and unorthodox healthcare system to operate together:

> *"Our interaction with TFHs gives us the impression that they are the first point of call to treat mental illness. So, we have been interacting and sensitising them to make an effort to refer cases that are beyond their control. We are discouraging the excesses such as chaining or shackling of agitated patients. I think the two treatment systems can run side by side. So yes, TFHs have a relevant role to play."*
>
> (IDI, Clinical Psychologist)

A legislator stated that because we cannot alter the beliefs of the people from seeking help at TFHs camps for mental health, it is possible to train these practitioners to collaborate and adopt modern methods of managing agitated patients:

> *"It is easier to train traditional and faith-based practitioners to incorporate modern techniques in handling people with mental illness. For instance, agitated patients could be referred to the health facility for management instead of resorting to chains."*
>
> (IDI_#02, Member of Parliament, Ghana)

A senior psychiatrist stated that TFHs play a role in mental healthcare, as shown in a number of studies (D. Arias et al., 2016; Drury, 2020; Gureje et al., 2015; Nortje et al., 2016b; Sessions

et al., 2017). This participant added that there is a need to educate these TFHs into a syncretic model of mental healthcare to provide better services to patients:

> *"I think they are, and because in our settings other studies that have been done, there are few of them that I have personally involved in which have proven that whether we like it or not amid all the education that you are given, people will still go to the TFHs and so the earlier we educate them and let them know the right things to do the better."*
>
> (IDI_#01, Psychiatrist)

An RMHC stated that most people with mental illness visit TFHs as the first point of call. Some TFHs have experience caring for people with mental illness and should be encouraged to collaborate with conventional practitioners in managing people with mental illness, especially those who are aggressive and need behavioural management:

> *"TFHs are very relevant because once a person develops a mental illness, the first contact is the TFHs. What we have done in the North is not discouraged their practices. We make sure that there are specific measures that when they have an aggressive patient, they call on the local mental health nurse to advise and treat the individual. A lot of TFHs have experience in the care of people living with mental illnesses."*
>
> (IDI_#06, RMHC)

Extending the discussion on the relevance of TFHs and the potential need for collaboration between conventional and TFHs, a community psychiatric nurse suggested a need to collaborate more since the mental health system cannot ignore the traditions, values and cultural influences that commonly contribute to explanatory models of mental health in Ghana. One approach to collaboration offered by this participant was for conventional practitioners to be allowed access to people with mental illness admitted to shrines and prayers camps to assess their health needs:

> *"I think we cannot write TFHs off like that. So, there should be a proper collaboration between the orthodox mental health practitioners and the TFHs so that while the patient is at the camp, at least a health worker can also visit such a patient periodically to assess their physical and mental health needs."*
>
> (FGD_#04, Community Psychiatric Nurse)

The practices of TFHs are not considered illegal under the MHA (Section 3 of the MHA), although practices such as chaining or caging, beatings, and force-fasting are outlawed. The GMHA has developed a guideline for TFHs to prevent abuses in the healing camps (Ghana Mental Health Authority, 2018). An RMHC indicated that people could not be prevented from

patronising the services of TFHs despite many of the abuses occurring in these camps being well known.

> *"We cannot say nobody should go to these places for treatment, but we also know that various abuses occur in some of these camps. You can have people who are hallucinating and being beaten to drive out evil spirits, people being chained and force-fasting."*
>
> (IDI_#04, RMHC)

The GMHA is an agency established by an Act of Parliament, Mental Health Act 846 of 2012, to propose, promote and implement mental health policies and provide culturally appropriate, humane and integrated mental healthcare throughout Ghana. Therefore, the GMHA recognises the role of TFHs in mental healthcare since people will continue to access their services. A senior RMHC employed under the GMHA further reinforces the importance of incorporating TFHs in a regulated form into the overall system of mental healthcare:

> *"Yes, TFHs play a huge role in mental health, and I think the MHA recognizes this. Whether we like them or not, these practitioners will be the first point of call for people with mental ill-health. Naturally, our belief system put TFHs in an advantageous position, so they play a key role. We should reorient TFHs to understand that it is an abuse of human rights when they keep people in chains or shackles."*
>
> (IDI_#07, RMHC)

A District Magistrate believed people should be encouraged to seek help from the health facilities for treatment regardless of their primary choice being TFHs, therefore encouraging a dualistic approach:

> *"My advice is that when people seek treatment from TFHs, they should also do the same from the hospital for treatment. People should be free to seek treatment from TFHs, but they should also take it upon themselves to seek treatment at the hospital."*
>
> (IDI, District Magistrate)

A number of clinicians trained and enculturated in the scientific method and evidence-based medicine acknowledged the paradox faced in incorporating TFHs care into a blended model of primary mental healthcare. The services of TFHs are considered important in bridging the mental health treatment gap. A CPO felt that TFHs are not only important because of the beliefs that will lead people to patronise their services, but also access to this type of mental healthcare will help relieve the burden on conventional health facilities:

> *"Yes, TFHs are very important; if not because of them, the mental health facilities will be chock-full. Moreover, I think we need to educate them about the orthodox way of administering*

treatment, which is most important. People prefer to go to them rather than the various psychiatric facilities because of the inherent belief systems."

(IDI, Clinical Psychiatric Officer)

A community mental health officer further reinforced the need for a pragmatic and pluralistic approach:

"There is a need to tolerate TFHs. Culturally, people's belief system is attached to our faith-based healers. Before someone with mental illness comes to the health facility, he or she might have gone around all prayer camps, fetish priests, pastors, and those kinds of people. Furthermore, because we are highly religious, anything that happens, we think that maybe it is someone who does not like me pushing you to this kind of condition, so there is the need to seek God's intervention."

(IDI, Community Mental Health Officer)

Several clinicians argued that improving the mental health literacy of TFHs would need to play a major role in disparate traditional practices to be consolidated into a broader model of mental healthcare. A community psychiatric nurse referred to an existing collaboration between a prayer camp and a health facility in the Central Region of Ghana:

"We need to start collaboration by educating TFHs about mental illness. There is one prayer camp in the Central Region that has started collaborating with the mental health nurses in the area. Whenever someone reports to this prayer camp with a mental health problem, the first point of contact is the mental health officer. From time to time, the mental health officer takes all the patients to the hospital for review and returns them to the prayer camp. The pastor makes sure patients take their medication while he does his spiritual things. So, that pastor has been educated and has understood the importance of medication and prayers."

(FGD_#02, Community Psychiatric Nurse)

Mental illness is highly stigmatised (Antonia Barke et al., 2011; Mfaofo-M'Carthy & Grishow, 2017), and there is a need to focus attention on training people, especially TFHs, to respect the rights of people with mental illness; this is enshrined in the constitution of Ghana. A Municipal Director of the CHRAJ discussed the importance of training TFHs to protect the rights of patients:

"Our focus should be on training spiritual healers against inhumane treatment of patients' because mental illness is a highly stigmatised condition. However, the constitution of Ghana, the supreme law, provides that everybody is treated fairly and equally irrespective of tribe, background, and health status. So, the TFHs need to be educated to understand that patients' rights must not be violated in that manner."

(IDI, Municipal Director, CHRAJ)

Further education with mental health staff concerning the legal statutes, coercive power, and legal responsibility under the MHA is needed. Regarding the very limited treatment environment for people with mental illness, an RMHC indicated that there was still much to be done to improve the provision of mental healthcare, as stipulated in the MHA:

> *"We still need to educate mental health staff about the MHA. We have started training staff about the Quality Human Rights, but all staff have not been trained yet; you know the procedures for involuntary admission are provided for in the MHA, but it is now down to the hospitals to implement that statutory provision of the MHA."*
>
> (IDI_#01, RMHC)

A participant from the policymaker group indicated that in order to monitor and prevent the abuse of people in traditional and faith-based camps, it was necessary to educate the healers and the general public to report such cases to the authorities:

> *"As a process, we need to educate the public and the leaders of traditional and faith-based camps about human rights. TFHs must know what to do and what not to do as healers. Furthermore, once the entire community is educated and sensitised about this, they will start reporting human rights violations from the camps of TFHs to the appropriate bodies for redress."*
>
> (IDI, Municipal Health Insurance Authority)

A District Magistrate said it was important that all stakeholders act to protect the rights of people with mental ill-health. This participant explained that he sometimes refers some accused persons for psychiatric assessment based on their appearance and demeanour during Court proceedings:

> *"The Judiciary is also a stakeholder like other institutions and must play its part to protect people's rights with mental illness. For instance, I sometimes refer accused persons to the Court for psychiatric assessment based on their demeanour or medical evidence. The prosecution is usually instructed to refer such persons to the psychiatry hospital for assessment and treatment before the Court proceedings could continue."*
>
> (IDI, District Magistrate)

Contributing to a discussion on protecting the human rights of people with mental health disorders, the Magistrate stated there was a need for further public awareness of what constitutes human rights abuse under the MHA:

> *"There is a lack of education about human right violations by TFHs, hence the need for public education. Unless the abusers are brought before the law Court, the Court cannot take action independently. If someone is tied to a tree for instance, and the case is not reported to the Court, as the Magistrate, I cannot act because I will not even be aware of such an incident. So, we need the public to report these violations to us."*
>
> (IDI, District Magistrate)

Regarding the role of key stakeholders such as the Police Service, a senior mental health professional suggested a need to train police to understand the MHA tenets and deal appropriately with issues that arise when people with mental illnesses come into contact with the criminal justice system. This was considered necessary due to the possibility that some offenders may have mental health conditions and would be better managed by health services rather than being prosecuted through the Courts:

> *"We need to train the Police Service because they might be the first persons to contact persons with mental health illnesses who have offended the law, so we need to train them to appreciate the issues. In some cases, the Police will need to bring them to us as health workers rather than prosecute them or send them to Court. So, yes, Police Service has a significant role to play to prevent human rights abuse."*
>
> (IDI, Senior Mental Health Administrator)

A senior policymaker in discussing the illegal practice of chaining within the faith-based camps asserted that enforcement is not the responsibility of the GMHA but rather sits with the Domestic Violence and Victim Support Unit (DOVVSU) of the Ghana Police Service:

> *"Chaining and flogging of patients amount to human rights abuse which is beyond the Ghana Health Service or the GMHA. As a human rights issue, we had advocated that when such crimes occur, the DOVVSU office of the Ghana Police Service should take over the case and not the GMHA."*
>
> (IDI, NCCE)

Apart from education, which it is hoped will foster collaboration between conventional mental health services and TFHs, there is the need for antipsychotic medication to be made available to treat people with mental illness at the traditional shrines and prayer camps. This will minimise the use of chains and shackles to manage patients who are hostile at these camps:

> *"We cannot do away with TFHs in African. Education will facilitate most of the collaboration between conventional healthcare and the TFHs. However, we also need to have some resources such as psychotropic medication for patients at those camps so that TFHs can continue to do their spiritual healings."*
>
> (FGD_#03, Community Psychiatric Nurse)

The complexity of reforming mental health services within low to middle-income countries with inadequate resourcing is highlighted in the following passage from an interview with a community mental health nurse. The nurse can see limited alternatives to restraint if there is no consistent supply chain of psychotropic medication. He pointed to a need for sufficient

medication so that when patients had chains removed, they could be managed appropriate to their mental health needs:

> *"Assuming you go to a faith-based healing camp and a patient is put in chains, and because the MHA outlaws chaining, you asked them to remove the chains. At the same time, that patient is very aggressive, so they put him in shackles. When the chain is removed, and the patient hurts someone or goes outside to commit a crime, whose fault is it? So, we have to provide psychotropics to administer to the patient and educate the healers to monitor the patient's progress. That is one way we can collaborate with faith-based healers."*
>
> (FGD_#03, Community Psychiatric Nurse)

Some community psychiatric nurses considered the best way for the health sector to collaborate with TFHs was through dialogue, seeing TFHs as partners in mental healthcare. It was thought this would reduce suspicion and resistance from these TFHs. The following excerpt highlights a working example in the Kintampo area:

> *"We collaborated with the Blood of Jesus prayer camp at Kyeremankuma [a suburb of the Kintampo township]. Sometimes, when our visit date to the prayer camp has elapsed, the head paster calls to remind us. The pastor confesses that our medicine works very well because it makes the patients feel good and relaxed for him to perform his prayers well. So, we need inter-sectorial collaboration. If we approach these healers without the mindset of collapsing their business, their arms will be opened for collaboration."*
>
> (FGD_#03, Community Psychiatric Nurse)

The majority of people interviewed agreed on the need for the GMHA to take a lead in guiding the practice of TFHs into an integrated and functional collaborative model of care. The following quote summarises the views of the majority of non TFH participants about the need for integration:

> *"The GMHA is trying to formalise some of these healers' activities, through sensitising them about the MHA and how to care for patients under their care in terms of where they keep the people; the chaining aspect and all that, their feeding, etc. Besides, we have introduced registers for some TFHs to keep records of patients who visit the camps and what interventions were taken to manage clients' conditions."*
>
> (IDI_#09, RMHC)

One of the pastors from a Pentecostal church acknowledged the importance of working with other health practitioners stating that he usually refers patients to the hospital first for the physical examination and then undertakes his spiritual healing afterwards:

> *"When it comes to the physical aspect, I interact with clinicians. When someone comes to me, I notice that the individual has not been to the clinic; first, I give them the chance to consult a clinician. However, when I notice that the person requires prayers, I take them in. However, if it requires physical medical intervention, I hand them over to the clinicians."*
>
> (IDI, Pastor)

An NGO mental health support agency representative advocated strongly for the need for a syncretic approach to managing mental illness. According to this participant, the dual approach will allow the two treatment systems to operate simultaneously:

> *"TFHs need to understand that the days of exorcising people claiming that their conditions are spiritual is over; although the MHA does not outlaw prayer camps, the practice as it has been prescribed is that you still let the person have access to conventional medications and formal treatment so that if the person still believes that prayer will heal him or her, that is fine. However, first of all, let the person seek orthodox treatment and then add aspects of their belief."*
>
> (IDI_#03, NGO)

A further community opinion leader acknowledged the need for a more pluralistic approach to mental health treatment and care, albeit arguing that the first contact and assessment should be with the conventional healthcare system:

> *"We should let people know that the first contact for the treatment of mental illness should be the hospital. You go to the hospital first for assessment and care; you can later on also go for your spiritual healing. Nevertheless, the hospital should always be the first point of contact for help."*
>
> (IDI, Community Opinion leader)

A representative of an NGO in acknowledging the cultural importance of traditional and faith-based healing to Ghanaians asserted that conventional mental health services need to be more available and relevant if they are further engaging with the Ghanaian community. This participant added that TFHs should be educated and encouraged to refer cases of mental illness they cannot handle to the conventional mental health facilities for treatment:

> *"I think we have to work hard to make mental health services widely available, relevant, and more efficacious than traditional and prayer camps. If I go to a hospital or a community psychiatric unit, I should see a kind of treatment that will be very different from what I get from the prayer camp, and that will not make it necessary for me to go to a traditional or prayer camp again. We also have to encourage traditional and faith-based practitioners to make referrals and reduce the kind of things they cannot do but claimed they could."*
>
> (IDI_#01, NGO)

As discussed earlier, the inter-sectoral interface between TFHs and Government is tenuous and needed strengthening to ensure successful collaboration. A traditional healer stated that there is no fiscal initiative from the Government to support TFHs to manage people with mental illness:

> *"We are requesting support such as accommodation facilities and other logistics from Government to accommodate patients. Sometimes people send their relatives with mental disorders to different shrines for help before being directed to my shrine. When that happens, they always spent all their monies before getting here, and I cannot also refuse to admit them into my camp to go and die."*
>
> (IDI, Traditional Healer)

A mental health service user was highly critical of Government agencies responsible for supporting people with mental health issues. This participant also disclosed that he lost his security service job because of his mental illness, which, according to him, was a contributing factor for his mental condition:

> *"I have never benefited a penny from any agency because of my mental health condition. Recently I lost my job as security personnel in January 2019 because of my mood swing. Since I was fired, I have not received any support from anywhere, including the District Assembly, Social Welfare Department, National Health Insurance Authority."*
>
> (IDI, mental health service user)

8.8 Practices and experiences of TFHs

Participants discussed the practices of and experiences with TFHs, including the causes of mental illness, diagnosis and treatment, management of agitated patients, and human rights abuse associated with TFHs.

8.8.1 Causes and diagnosis of mental illness

TFHs use different ways to diagnose diseases, including mental illness. According to a church Pastor, dreams and speech patterns can assist in determining which sickness belongs to the spiritual realm and which does not:

> *"One way to diagnose mental illness is through dreams. Whenever the patient wakes up, we ask about their dreams, and this is how we get to know if a spirit possesses that individual. Also, an individual speech pattern signals whether the sickness is spiritual or not."*
>
> (IDI, Church Pastor)

A Muslim healer indicated there are different mental illnesses, some are spiritual, and others medical. According to this Muslim healer, he treats mental illness caused by spiritual forces and refers to those that he described as medical to the medical doctors to manage:

> *"Yes, I do treat mental conditions when it is spiritual. I believe that there are so many types of mental illness; some are spiritual, and those we treat, those that are medical, we do not even venture because we do not have the know-how. So, when the person is supposed to be mentally ill, we ask that they send him or her to the hospital for a special check-up. If they fail*

to diagnose and manage the problem at the hospital, the person is referred back to us for spiritual treatment and that we do so much."

(IDI, Muslim Healer)

The same Muslim healer explained that he consults the patient's carer to establish if the hospital identified the illness or disease's aetiology, and if not, interprets the causation to be spiritually influenced. According to the Muslim healer, the hospital report would have indicated that they did not detect anything wrong with the patient. This is usually a verbal report from the carer. He then concludes that since the hospital was unable to detect or diagnose the illness, it means that such a person is suffering from spiritual problems which are within his power to treat:

"As healers, we do not have machines to diagnose mental illness, and usually, when the patient's problem is spiritual, hospital machines cannot detect it. I always request that the person is taken to the hospital first for a thorough assessment, and if it is what the hospital can handle, that is fine; if the hospital seems not to have seen anything wrong with the person, then we know it is spiritual. So, we use the feedback from the hospital to determine how to treat the patient."

(IDI, Muslim Healer)

The same Muslim spiritual healer provided further insight into the complex illness narrative of African-Islamic healers and belief system concerning spirit possession and causes of mental illness:

"Spirits can enter a person's body through one of 32 entrances when such a person exposes his/her body, so the spirits go into the body and possess it. If the possessed person goes contrary to the spirit's wish, the spirit will inflict mental illness on the person. Usually, that is the leading cause of mental illness. People can also seek spiritual support from Mallams or fetish priests to inflict mental illness on other people."

(IDI, Muslim Healer)

Rituals and prayers form a major part of treatment at the traditional and faith-based healing camps. According to a Church Pastor, fasting, including periods of dry-fasting and prayer, was considered essential to mental health healing:

"I do not give out medication here. All I have to do is fast and pray for healing for the patients. When you fast, you have to accompany it with prayer. You cannot fast without prayers. As you fast, you pray. We always pray with the patient for healing."

(IDI, Church Pastor)

The delicate inter-sectoral interface between Ghanaian religious therapy as practised within the prayer centres and biomedical providers was highlighted by a church Pastor when discussing the need to withhold prescribed medication during fasting. When people with mental illness visit a faith-based healing centre with medication previously obtained from a clinician, in such instances, the patient is only allowed to take the medication during periods in which the patient is not undergoing fasting:

> *"We give the patients a chance to take their medicine while at the prayer camp. However, when fasting begins, we do not allow them to take their medications until the fasting is completed. This cycle repeats itself; then, little by little, the patient will be fine and out of the problem."*
>
> (IDI, Church Pastor)

The common illness narrative offered by church pastors and prayer centre prophets focussed on the metaphysical causation of mental illness and the importance of invocating of God through prayer and fasting; no medication is required for healing:

> *"Mainly I treat spiritual sicknesses. When an individual sees me with spiritual sickness, and I notice that the person is afflicted spiritually, that spirit ends, leaving the person through my intervention. Therefore, with that, no medication is required. This has to do with fasting, prayers, and the teachings of the word of God many times. As soon as the individual receives God's word, the spirit cannot reside in the person any longer; it has to disappear."*
>
> (IDI, Church Pastor)

According to this same TFH, he was emulating what Jesus Christ did to heal people while on earth, as recorded in the Holy Bible:

> *"Matthew 8:16, "When evening had come, they brought to Him [Jesus Christ] many who were demon-possessed. And He cast out the spirits with a word and healed all who were sick". God's word overpowers any evil spirit. For instance, when an epileptic person hears the word of God, the spirit inside that individual hears it. Thus, the spirit forces that person to fall on the ground; the spirit eventually escapes from the body"*
>
> (IDI, Church Pastor)

A Muslim healer discussed how he uses Islamic concepts and religious rituals from the Quran as self-help strategies to cure mental illness:

> *"After listening to your problem, I will copy recitals from the Quran to a memory card or stick for you. I will ask you to listen to the recital every morning and every evening at least for twenty-one days, updating me every three days, and before you are done, everything is fine, and you are cured."*
>
> (IDI, Muslim Healer)

A TFH discussed healing from an African cosmological perspective where he claimed a metaphysical force guided his traditional practice. This participant stated the spirit always directs him at the shrine about the type of herbs to use for treatment:

> *"The spirit always directs me as to the type of herbs I should use to treat a patient. I treat many sicknesses; some are burning sensations, people who have been struck by "juju" (black medicine), and those who need protection. If you are travelling and need spiritual guidance, I can support you spiritually; I also help those who want to travel outside the country. The moment I pray with you, every document will be given to you, even if they have arrested your relative in another country and you get a family member to represent him or her at my shrine; I will pray with the family member the person will be freed."*

(IDI, Traditional Healer)

The TFH indicated that he uses only local traditional herbs to treat mental illness at his shrine:

> *"One thing about the shrine here is that only herbs are used to treat people with mental illness; I do not combine herbs with any hospital medicine."*

(IDI, Traditional Healer)

8.8.2 Treatment duration, outcomes and coverage

Traditional illness narratives still dominate in Ghana, conceptualised within a naturalistic sense where mental illness is seen to originate from supernatural forces (Ae-Ngibise et al., 2010; Asamoah et al., 2014; Gureje et al., 2020). Several faith-based and traditional healers discussed the effectiveness of their interventions. A pastor from a prayer healing camp indicated that the duration of treatment for mental illness depends on the type of illness. The pastor added that the type of illness would determine whether a clinician can treat it or not:

> *"Duration of treatment depends on the type of sickness. It takes longer for some people, while others make progress at once, thus allowing them to be discharged from the prayer camp early. For instance, two weeks ago, someone came here to seek my help. While the person was sitting down, she kept repeating, "they are going to catch me… they are standing here… they are sitting on this tree branch." The doctor cannot help with something like that. Hence, when you start healing that individual, they will be healed and discharged in less than a week."*

(IDI, Church Pastor)

A Muslim healer stated that he does not admit people with mental illness into his camp because he can cure patients within hours of consultation:

> *"No, no, we do not admit anybody in my house. You come with the case, I sit on you INSHA-ALLAH [God willing] within an hour or two; everything is done."*

(IDI, Muslim Healer)

A TFH also stated that the duration of treatment at his shrine depends on early presentation and diagnosis. Patients who report to the shrine at the onset of their illness may be cured between two to three months, while those who delay in reporting to the shrine can stay more than a year:

> *"The duration a patient spend here depends on the early arrival of the patients to the shrine. Those who are brought immediately at the start of the mental illness are treated within two to three months. Some, too, I can use three or four days to cure the illness. Some patients stay at my shrine for six, seven months, and others also stay for a year or even more before they are discharged."*
>
> (IDI, Traditional Healer)

A Muslim healer claimed that he receives calls from outside of Ghana for the employment of Islamic concepts and religious rituals that cure people with mental illness:

> *"I cure many people from different places. Some people even call from outside Ghana, and I always hand over whatever I use for the deliverance to them, and then they do it, and the person is delivered. Even today, I was called from Accra to do deliverance."*
>
> (IDI, Muslim Healer)

Similarly, a traditional healer stated that he could cure all patients including patient who have been unsuccessfully treated at the psychiatric hospital:

> *"Since I took over the shrine management, all cases of mental illness that have come here have been treated successfully and discharged. I have had a hundred per cent treatment success rate. There are even instances where patients are brought here after unsuccessfully seeking treatment from psychiatric hospitals, and I always heal them with my local herbs. I can boldly say I have treated and discharged people living with mental illness for six, seven, and even forty-five years."*
>
> (IDI, Traditional Healer)

TFHs stated that they do not use the mainstream services to advertise their practice; instead, people who have been treated successfully publicise the positive outcomes in testimonies. A traditional healer stated:

> *"I do not advertise my work on radio stations or other platforms; instead, it is the families of those who have been cured by my herbs here that advertises me."*
>
> (IDI, Traditional Healer)

Management of acute psychotic episodes by TFHs can be challenging due to the absence of psychotropic medicine. A TFH explained the purpose of chaining people who had mental illness in the period before the implementation of the MHA. According to this TFH, restraining agitated patients with chains allowed for the patient to receive the word of God as part of the healing process and also preventing them from causing harm to themselves and other people:

> *"Yes, we used to chain patients to prevent them from hurting themselves and others. When you lock the patient, I can get closer to the individual to preach God's word repeatedly. Once the word fills the person, they get better."*
>
> (IDI, Church Pastor)

A TFH described the outlawing of chaining people with mental illness in the prayers camps as not helpful because he was no longer admitting patients who are aggressive. This is affecting those who cannot pay for the services at the health facilities:

> *"The law is not very helpful because people are suffering; they cannot afford the cost of treatment at the health facilities, and I am not allowed to chain them because of the law. The services I offer are free."*
>
> (IDI, Church Pastor)

8.8.3 Mental illness and human rights abuse by TFHs

In some spiritual healing camps and shrines, people with mental illness are often chained to trees, frequently exposed to the elements, and forced to fast for weeks as part of a 'healing process,' while being denied access to medications (Ssengooba et al., 2012). The study participants discussed practices that violate people's rights with mental illness in orthodox and unorthodox health systems.

Agitated patients or those that refuse to adhere to the healer's interventions and rituals are chained and flogged but with no cure at the end. A mental health service user recounted:

> *"When my sickness started, I did not know where to seek help. Because I was mentally unwell and agitated, I was tied up before treatment. That is the method used by pastors and herbalists to manage agitated patients. We would have accepted this method if we were getting better afterwards. You will be tied up, and if you are unlucky to find yourself in the hands of a wicked healer, you will be flogged severely anytime you refuse to take their herbs."*
>
> (IDI, Mental Health Service User)

While it is widely acknowledged that many Ghanaians turn to TFHs for support and treatment for mental illness, other participants pointed out the human rights violations by many of these practitioners. A local Government administrator and a Divisional Police Commander took a different position, arguing that TFHs do not have a role to play within primary healthcare. These

participants added that TFHs are thwarting efforts at improving mental healthcare since, in his opinion, these practitioners cannot diagnose and treat mental illness:

> *"For primary healthcare, TFHs are not relevant; how do they even determine who is ill? I am talking about the diagnosis; you do not know the type of sickness; how can you cure that sickness? It is only when you know so they are hampering our effort to eliminate mental health problems in the country."*
>
> (IDI, Local Government Inspector)

> *"No, no, I do not believe in these faith-based healing because they cannot treat or cure people living with mental disorders. TFHs only end up worsening the patients' health condition."*
>
> (IDI, Divisional Police Commander)

Further, a Municipal Health Insurance Authority Manager took a similar stance, arguing that the services of TFHs are not scientifically based and are inimical to the wellbeing of people with mental health issues and therefore have no role to play in modern mental healthcare. The manager remarked:

> *"In fact, in this modern era, I will say there is no place for TFHs. I will say no because most of these healers' activities are not scientific-based, and I have seen people chained in the churches and other places; their condition did not improve."*
>
> (IDI, Municipal Health Insurance Authority Manager)

A Social Welfare and Community Development representative discussed the central issue of spiritual determinism in mental illness and the need to improve the community's general mental health literacy for mental health reform to move forward. Despite various participants not supporting TFHs, there was an acknowledgment that people would continue to seek healing from them because of entrenched beliefs linking mental illness to spirituality. This participant stated:

> *"In the contemporary world, I will say we no longer need TFHs, but it is the people's beliefs, which I think before we can disabuse that belief, we need mass education. People believe that when a person has a mental illness, the only place to cure it is to go to a pastor or a traditional healing camps. They will be seen to be healed, but the disease will resurface."*
>
> (IDI, Social Welfare and Community Development)

A number of the mental health service users and carers interviewed within this study strongly argued that TFHs were not effective in curing mental illness. Some of these participants contended that TFHs demand money and other items from them, yet patients do not normally

get treated. This is in sharp contrast to what the TFHs discussed, which indicated that they offer free services to patients under their care:

> *"TFHs are of no help to us because they request money and other items from us; after they take everything, including our monies, the sickness remains, no positive outcome."*
>
> (FGD_#06, Mental Health Service User).

> *"What my sister said is true, TFHs will ask you to bring a lot of things. If you do not take care, you will give TFHs all your money and other resources, but you will not see any improvement in your relative's condition."*
>
> (FGD_#02, Carer of a Mental Health Service User).

Another carer of a mental health service user stated that sometimes people are required to perform animal sacrifices, which may worsen the situation:

> *"The day that we went to make sacrifices such as offering dogs and fowls, that was the night that we could not even sleep. For me, I have realised that fetish priests are of no help to us. You will waste all your resources when you go to them and not get the cure you seek."*
>
> (FGD_#07, Carer of a Mental Health Service User).

A mental health service user described the basic conditions that patients are exposed to when being treated by Indigenous healers including herbalists and fetish priests:

> *"The herbalists and fetish priests are very annoying. You will have to stay at the shrine for some time with infestations of insects. However, nothing annoys me more than when nothing changes after you have complied with all the directives by the fetish priest."*
>
> (FGD_#01, Mental Health Service User).

The parent seeking treatment for their child described their engagement with a sharman:

> *"A fetish priest said witches wanted to kill my daughter and that they engaged in a witchcraft deal over her. The priest asked that I pay for him to engage the witches in a spiritual fight. This fetish priest said that they will die after shooting the witches and will stop worrying my daughter. I paid the money but did not see any changes in my daughter's condition. The priest gave me further directions to buy schnapps, and I complained that if the guns could not kill the witches, what can schnapps do? I stayed at this shrine not because I thought it would help my child but because I had no other option."*
>
> (FGD_#04, Carer of a Mental Health Service User).

Many participants from the mental health service users and carers group pointed out that TFHs were not successful in treating people with mental disorders, indicating a loss of relevance and ineffectiveness of these practitioners in treating mental illness:

> *"I did not get any help from TFHs because my sickness continued to persist after roaming from one faith-based healing to another."*
>
> (FGD_#01, Mental Health Service User).

> *"It was of no help going to see the traditional healer. It did not go well for me because my health condition even worsened at the healing camps."*
>
> (FGD_#06, Mental Health Service User).

Some of the carers explained that "it did not go well", which meant no cure for mental ill-health was obtained at the traditional and faith-based healing camps:

> *"Our relatives have taken herbal medicine, but it all did not help the situation. As they say, we will buy live chickens, goats, kola nuts and several items to be used by the healer for the treatment. You will be given herbal medicine for drinking and bathing, but all that did not help."*
>
> (FGD_#03, Carer of a Mental Health Service User).

It was considered that some TFHs were taking advantage of the conditions of people with mental illness to extort monies from them disguised as 'healing'. According to these participants, monies are sometimes collected by TFHs from people seeking healing to buy the items for the performance of the rituals, yet they will not be healed from the sickness:

> *"When you go to TFHs, they sometimes tell you to bring money before you can be attended to, and pastors are not supposed to do that."*
>
> (FGD_#07, Carer of a Mental Health Service User).

> *"Sometimes fetish priest request for money from to buy many items for the healing, yet they are unable to cure the sickness after buying all the required items. We are tired of buying witchcraft medicine. So, for these healers, if you follow them, you will spend all your money."*
>
> (FGD_#03, Carer of a Mental Health Service User)

A mental health service user discussed a system of fee-for-service applied by a pastor:

> *"At times patients pay consultation fees to meet with a pastor but sometimes denied the opportunity to meet them. Before you get to meet the pastor, you have to spend a lot of money. Where I visited, I had no bath for three days due to a lack of a bathing facility. Other patients paid equivalent of between US$ 800 – US$1000. Some patients paid US$100 and still did not meet the pastor. If your money is within US$50 like some of us, then they will just sprinkle some water on you and ask you to go home."*
>
> (FGD_#01, Mental Health Service User).

In contrast to a number of the previous service user positions on the efficacy of faith healing, the following mental health service user claims that prayers alone without medication will not cure illness:

> *"I will say a hundred per cent no to TFHs because they do not have the requisite training and technical knowledge to cure mental illness. The faith-based healers will pray for you, but you will not be healed if you do not take any medicine."*
>
> (IDI, Mental Health Service User)

Some of the study participants, including the mental health service providers, indicated that abuse of patients by TFHs was a major concern. Participants believed that many of the TFHs were naïve of the fact that their practice constituted maltreatment and violation of human rights. Further to this, outside of chaining and flogging, it was suggested that the TFHs were devoid of other strategies for supporting agitated and at-risk patients. Patients are forced to fast, are chained, and sometimes beaten or flogged to "chase evil spirits away". A clinical psychologist advocating for further education for TFHs suggested there is a need to educate TFHs about such practices and insist TFHs refer agitated patients to conventional health service providers:

> *"When you talk to TFHs, they do not see abuse in what they are doing. So, the angle we are coming from is to educate them to understand why those acts are abusive. TFHs also lack a strategy for managing agitated patients, and that is the root of the abuse. So, we tell them that if the patient is violent, it does not mean that you tie them to make the person calm; instead, refer such patients to the health facility."*
>
> (IDI, Clinical Psychologist)

A Municipal Director of Health Services also stated a need to sensitise TFHs to realise that what they are doing violates patients' rights. According to this senior health administrator, TFHs consider their practice as the right thing to do in order to support the patients:

> *"We have to train TFHs; they feel that what they are doing is the right thing; those TFHs trained and enlightened are no more chaining and flogging patients. When they get an aggressive patient, they call the mental health nurse to come around and stabilise such a patient while they continue their spiritual healing."*
>
> (IDI, Municipal Director of Health Services)

Similarly, an RMHC stated that human rights abuse of persons with mental illness is public knowledge even though service users cannot be stopped from seeking the services of TFHs. The coordinator further stated that what is tantamount to corporal punishment in the form of flogging is administered to acutely unwell patients by TFHs supposedly to drive away evil spirits:

> *"We cannot say nobody should seek help from TFHs. However, we also know of various abuses that go on in some of these camps to help people with such conditions. So, you can have people who are hallucinating and being flogged to kind of drive out the evil spirit and all that, people being chained, people made to fast, and many things that are severe human rights abuse and against the tenets of the MHA."*
>
> (IDI_#04, RMHC)

A Municipal Director of the NCCE discussed his own religious identity and questioned the juxtaposition between spiritual healing and human rights violations. He does not trust the practices of chaining and maltreating patients as part of treatment offered by TFHs:

> *"I am not a believer in TFHs; I am a Muslim, but I do not believe in spiritual healing either from the Christian or Islamic perspective; I do not believe in both. These spiritual practitioners chain the people they are supposed to heal. How do you heal somebody while chaining or beating the person? So, I will not advise any patient to resort to those treatments."*
>
> (IDI, NCCE Director)

The MHA is the main piece of legislation covering the assessment, treatment and rights of people with mental disorders. Notwithstanding this, people with mental and psychosocial disabilities in Ghana continue to experience human rights violations in their everyday lives. There is a systemic lack of public awareness regarding employment and the rights of people with mental illness. A mental health service user who was dismissed from his job as a security person did not report the incident to any law enforcement body due to a lack of awareness regarding where such matters ought to be reported. He did not know that he could get help for reinstatement or even compensation from the organisation that dismissed him due to his mental health condition:

> *"I was sacked from my job because the manager said I had bipolar disorder. I did not commit any treachery or any evil thing, but they sacked me just because of my mood swing at the workplace. I never reported the issue to any institution when I lost that job at my former workplace in the Greater Accra Region. Moreover, I did not know any human rights institution to report the matter to seek redress. I was not given any pesewa for compensation."*
>
> (IDI, Mental Health Service User)

Lack of awareness of what constitutes human rights violation is evident in the extreme example offered by an RMHC in describing an accepted practice of gender-based institutional violation of vulnerable persons' human rights. There were instances in the past in which female patients were given injections without their consent to prevent them from becoming pregnant by people trying to take advantage of their mental health condition:

> *"For instance, some men take advantage of females who had mental illness and got them pregnant, so there were instances where we needed to give these patients injections that can protect them from getting pregnant, so you realise it was against their fundamental human rights to do that without their consent, but we did it in the interest of the patient."*
>
> (IDI_#06, RMHC)

The substantive impact of introducing the MHA in Ghana remains challenging to evaluate, albeit some evidence suggests that human rights violations are being identified and challenged. Human rights abuses such as chaining patients to trees and shackling in prayer camps and traditional healing homes continued despite the introduction of the MHA:

> *"As we speak currently, I know of a boy; both of his legs have been locked in a shackle. His rights have been 100% trampled upon. Every day he walks in the shackles up and down, so you can see his legs are swollen. When you see him, you will think he is an animal."*
>
> (IDI, Mental Health Service User)

This mental health service user considered there was a need for treatment at the health facilities for patients in shackles to recover from mental illness:

> *"The only thing that could help this patient is for the health authorities to ensure treatment at the mental health facilities for patients to recover. Instead, they have locked the legs of this guy every day; he is walking with the shackles in town."*
>
> (IDI, Mental Health Service User)

8.9 Mental health service users experience of TFHs

Mental health service users and carers shared experiences about their encounters with TFHs. Some participants considered that human rights abuses would likely continue due to a lack of appropriate and dignified means of restraining or managing patients who were aggressive in traditional and faith-based treatment camps. Although some NGOs indicated they had been training some TFHs, there was still a lack of understanding among some healers that chaining people with mental disorders violates these people's rights. A traditional healer stated:

> *"We will still chain them because we have no other means of restraining aggressive patients' at the camps."*
>
> (IDI, Traditional Healer)

This TFHs position regarding chaining people with mental disorders points to a lack of knowledge about the provisions and dictates of the MHA and the need for the GMHA to intensify targeted public education on the values inherent within the MHA:

> *"Many human rights violations occur at the traditional and faith-based healing camps, including forcefully restraining patients, flogging and directing patients to go without food for extended periods. To end this inhumane treatment by TFHs, people need to stop visiting their camps for help."*
>
> (FGD_#01, Mental Health Service User)

The Ghanaian concept of health and sickness can be described as naturalistic as it views mental illness from a broader cosmological perspective where supernatural forces influence behaviour. In circumstances in which a person is unwell and searching for a cure for their mental illness, they are sometimes instructed to observe fasting (going without food) for extended periods as part of healing. It was suggested that a person's condition could worsen, or they could die due to some of the rituals performed in healing camps:

> *"You see, the shrine is not a comfortable place, and it is not our wish to go there, but just as the saying goes, "The devil's sickness is treated with the devil's medicine." When you find yourself in a tight spot, you will comply with wherever you are told to go."*
>
> (FGD_#01, Mental Health Service User)

> *"When this illness comes, you will comply with wherever you are asked to send the person for treatment. My child could be asked to fast for two months; we could fast for a month and two weeks without any food, only water. My child grew so lean in the process. So I have realised all those things are unimportant and could result in people's death."*
>
> (FGD_#04, Carer of a Mental Health Service User).

Comments provided by a number of mental health service users highlighted the intrinsic nature of compulsory fasting and chaining. The experience of such maltreatments, including compulsory fasting and chaining of people with mental ill-health, also occurs in churches. A mental health service user experienced this even at a time in which she was pregnant:

> *"I was even pregnant at that time when my sickness started. I was pregnant with my first child and was chained for three weeks. I was given just water and no food. Near the church, I was tied up in a bush somewhere like a cow."*
>
> (FGD_#06, Mental Health Service User)

Similarly, a carer stated:

> *"My son, a very nice-looking young man, was tied up at prayer camps and kept on the floor like a cow."*
>
> (FGD_#05, Carer of a Mental Health Service User).

Sometimes abuses at traditional and faith-based healing centres were orchestrated by other patients in the healing camps, suggesting a lack of security and safety. A service user and carer confirmed:

> *"Sometimes when you are asleep at the healing camp, another patient can whip you with a stick. There is no comfort, and there is nothing you can do about it."*
>
> (FGD_#06, Mental Health Service User).

> *"Other patients sometimes orchestrate human rights abuse at the camps. One day I went home to prepare some food for my child, and upon my return to the prayer camp, I saw that another female patient had beaten my daughter so badly and even tore her dress."*
>
> (FGD_#04, Carer of a Mental Health Service User)

Human rights violations within faith-based healing centres extend beyond corporal punishment to neglect of personal needs, lack of security measures and lack of human contact. Other health concerns at the camps included individuals who had been chained in the bush and were not permitted to have relatives stay to assist them. The following excerpt from a mental health service user exposes the extent of human rights violation:

> *"When my child was sent to the bush by a pastor, I requested to stay by her, but I was not allowed. She was staying in the bush with only water without food. During the rainy season, she was exposed to the rain, worms and insects. As a result, I told the paster I would not allow my child to stay at that place any longer, and people accused me of being a witch because I do not want my child to stay at the church again."*
>
> (FGD_#04, Carer of a Mental Health Service User)

A traditional community leader discussed the pressure placed on family members to take their loved ones to a fetish priest or TFH, regardless of the inhumane treatment at these camps. In some instances, the individual can be confined to these treatment camps for many years without improvement in their mental health:

> *"Many people usually insist that the family take them to the fetish priest, especially in some spiritual churches. They are taken to these places and are chained. Sometimes patients will be at these places for many months or years and still do not heal."*
>
> (IDI, Community traditional leader)

Another area that participants discussed was seeking multiple treatment options for mental illness. In Ghana, as in other developing African countries, a high percentage of the population practice medical pluralism seeking treatment from conventional and unorthodox sources (Ae-Ngibise et al., 2010; Read, 2012). A carer of a mental health service user in a focus group discussion described how they had visited several places searching for healing and concluded that orthodox treatment is better than herbal treatment:

> *"Since the illness started, we have been to many places for treatment. We have tried numerous herbal medications. In the beginning, we went to Ankaful psychiatric hospital in Cape Coast, we have been to Accra Psychiatric hospital, we have been to every hospital that*

treats mental health conditions. We tried herbal medicine as we have also tried western medicine, and we can say western medicine is better."

(FGD_#04, Carer of a mental health service user)

Mental health service users and carers stated that they had sought various treatment options for healing. Participants recognised the efficacy of orthodox treatment over traditional and faith-based options although were critical of the inconsistent availability of pharmaceuticals and in particular psychotropic medication which is a constant problem:

"We started with herbal treatment for some time and did not see any improvement. The sickness became severe, and my relative was admitted to a Government hospital for two weeks and discharged without disclosing the diagnosis to us. My relative's condition did not improve, and a neighbour directed us to the Psychosocial Centre, where we are currently receiving treatment. The medication at this centre has been helpful. The problem now is with the unreliable medicine supply."

(FGD_#3, Carer of a mental health service user)

Pathways to care for the mentally ill in developing countries like Ghana are often pluralistic and include traditional medicine. Unfortunately, little is known about the efficacy of traditional healing. The following excerpts by a carer of mental health service user highlight the dilemma faced by many Ghanaians when faced with seeking treatment for mental illness:

"When it happened, whenever someone suggested that we go, we went. Someone mentioned a place for herbal treatment, and we took him there until a point when his condition deteriorated. Another person informed us that there is treatment at the hospital, and truly when we came here, we got some medicine."

(FGD_#02, Carer of a mental health service user)

Similarly, another carer recounted how they visited different places, searching for treatment until they were directed to a hospital. These participants added that the medicine received from the hospital had been beneficial:

"When my child's condition started, we sent him to a church, and he was chained over there. It was not a pleasant sight. We have entered shrines where we had previously never thought about seeking help. We offered a dog as a sacrifice, but it did not help. We went to the Northern part of Ghana to see a pastor for treatment, but it still did not help. We stayed in the church for about a year, and that also did not work until someone suggested that I bring him to the hospital here, and it has been good so far."

(FGD_#07, Carer of a mental health service user)

A mental health service user reported never using TFH services for the treatment of his mental illness due to a lack of faith in their curative ability:

> *"Apart from the medicine that I take from the hospital, I have never visited any religious or traditional healer for healing because I do not believe in TFHs' ability to treat mental illness."*
>
> (IDI, Mental Health Service User)

8.10 Chapter summary

In this chapter, participants examined the role of TFHs in mental healthcare and their treatment experience. In general, participants, including policymakers, mental health service providers, and community opinion leaders, agreed that TFHs have an important role in mental healthcare because of the cultural and traditional belief systems that link mental ill-health to spirituality. The practices of TFHs is deep-rooted in the cultural belief system of the people of Ghana (Kpobi & Swartz, 2019). Mental health service users and their carers often utilise multiple treatment sources, including conventional and TFHs, with TFHs usually being the first choice of treatment for mental ill-health (Ae-Ngibise et al., 2010). People attribute things that are difficult to understand, including mental illness, to spiritual forces. The explanatory models of aetiology expressed by most TFHs interviewed indicated a belief in spiritual and supernatural phenomena beyond the physical world as causes of mental illness, and therefore beyond the treatment capacity of orthodox health services. In this study, TFHs claimed to be able to cure people with mental illnesses. Further to this, TFHs pointed to their services being free of charge, with patients accessing them anytime because of their proximity to the community. Poor access to conventional mental health services and the low cost of treatment by TFHs were also identified as important reasons for many people to seek help from TFHs. While most participants pointed to the important role that TFHs have and could continue to have in mental healthcare, they also noted the human rights abuses that have been linked to such practitioners at the faith-based camps and were firmly in favour of measures designed to ensure the cessation of all inhumane practices.

However, mental health service users and carers interviewed were against the practices of TFHs. These participants were not convinced about the safety and effectiveness of the services provided by TFHs; they argued that TFHs were not able to treat mental disorders; they subjected patients to human rights abuses including chaining or shackling, flogging or whipping, force-fasting, and sought payment in the form of money or goods for ritual performance, without improving the individual's health. These abuses have been reported elsewhere (Read, 2019). On the other hand, policymakers, service providers, and community opinion leaders considered that TFHs are important mental health service providers; however,

safeguards would need to be established to address human rights concerns linked to the prayer camps and traditional healing homes.

With most service users in this study suggesting that TFHs do not always cure them despite demanding items for ritual performances and prayers, mental health facilities should be sufficiently resourced to provide adequate services for people with mental illness. Service users and carers called on Government to ensure a regular supply of medication for patients; this would also encourage patients to utilise conventional health facilities. Participants also suggested educating TFHs about mental illness and the MHA to prevent or mitigate the abuses at the traditional and faith-based healing camps. Pluralism and dualism are almost ingrained in the cultural context, and some participants suggested a collaboration between the various treatment perspectives in the form of pastoral care to better serve the larger interest and needs of mental health service users and carers. As recommended in the global mental health policy (Wildeman, 2013) and other studies on the role of faith healing for mental illness, there is a need to formalise collaborations between conventional mental health service providers and TFHs to prevent human rights abuses and promoting mental health treatment that is holistic (Ae-Ngibise et al., 2010; Read, 2019). Regulating and monitoring the practices of TFHs is critical towards the prevention of human rights violations at faith-based healing centres. The GMHA is responsible for overseeing the activities of TFHs; the Authority will have to ensure there is a formal collaboration between the conventional mental health system and TFHs, as highlighted by a number of the study participants. Chapter 9 presents stakeholders' perspectives on the enablers for implementing the MHA.

Chapter 9 Stakeholders' perspectives on enablers for implementing the MHA

9.1 Introduction

This chapter reports the findings of qualitative interviews with stakeholders within the mental health sector in Ghana. This section of the research aimed to identify and explore strategies that mental health key stakeholders considered would facilitate the timely implementation of the MHA to promote mental healthcare in Ghana. The chapter begins with a discussion of the need for Ghanaian specific mental health research and advocacy to compel Government to provide resources for the implementation of the MHA. The need for mental health education and awareness as well as training and motivation for mental health workers, so they can play a role in the implementation of the MHA, is then discussed. This is followed by discussion of the importance of adequate mental health resourcing, collaboration, and regulation for TFHs; the role of stakeholders in implementing the MHA, the passage of the LI and ensuring that the provisions of the MHA are enforced. The chapter concludes with a summary of the strategies considered by the participants to be critical in helping implement the MHA.

9.2 Mental health research and advocacy

Participants discussed the need to increase community awareness of mental health issues through research and advocacy. There is generally a lack of mental health research in Ghana with only one percent of all publications on health focusing on mental health (Roberts et al., 2014) Participants argued that evidence from research about the burden of mental illness or the mental health situation in Ghana would support the calls for mental health reform. It was also thought this would promote mental health literacy and thereby decrease misconceptions about mental ill-health. It was identified that the lack of research may partly account for the extent of disinterest in mental health. As an RMHC commented:

> *"I think that we need to conduct more mental health research and publish the results. Once the results are published, people will appreciate the burden of mental illness and the need to pay attention to it. It will also serve as a basis to start specific arguments in favour of mental health funding. We do not do much research in Ghana on mental health, so most of the talking that we have is not based on empirical evidence, but since the World is growing, you need to have empirical evidence so that people will take you more seriously."*
>
> (IDI_#08, RMHC)

Some participants advocated for more research to be conducted into mental health which would support calls for the implementation of the MHA. It was considered that the way forward for ensuring the MHA is effectively implemented is to undertake more Ghanaian-based research on mental health systems and provide empirical data to convince stakeholders of the need to implement the MHA. A senior Psychiatrist stated:

> *"We, as critical stakeholders should do a lot of mental health research and argue our case out for the prioritisation of mental healthcare based on the facts and evidence available. Evidence on the ground may compel the authorities to invest resources in mental health. More so, we have to do much advocacy, much noisemaking, probably that will be enough activism to influence the allocation of resources for implementing the MHA."*
>
> (IDI_#01, Psychiatrist)

Another psychiatrist stressed the need to support calls for mental health services to be prioritised using evidence from research:

> *"Mortality and morbidity may not make a good case for mental health to be prioritised unless researchers can value the loss in terms of money, such as lost to the gross domestic product due to psychological disorders. This may change the lack of commitment of the central Government towards mental healthcare."*
>
> (IDI_#02, Psychiatrist)

A Municipal Director of the National Commission and Civic Education (NCCE) also suggested it would be important for mental health professionals and students to ask questions regarding the status of the MHA LI:

> *"I will suggest to mental health workers and students to ask these questions; where is the MHA LI? Why is the mental health fund not established? If we find answers to these critical questions, it will help facilitate the implementation process. So, I think we have to start conducting more research in this area to support mental healthcare."*
>
> (IDI, Municipal Director, NCCE)

Advocacy was one of the main strategies most of the policymakers and implementers considered could accelerate implementation of the MHA. A legislator and member of the 7th Parliament as well as a representative of the Municipal Health Insurance Scheme discussed the urgent need to lobby the MoF to establish the mental health fund. It was suggested that such an approach was more likely to encourage multi-lateral and donor organisations to also add their support to implement the mental health reforms:

> *"We should lobby the MoF as a matter of urgency to get the mental health fund established so that the MHA can be implemented. The main challenge is funding, and if we are able to establish the mental health fund, the challenges will be solved. I know many foreign agencies and donors are ready to contribute, but they need the country to take the first step in putting*

in the seed capital so that when we show that we are committed, donors can also come in and support with their donations."

(IDI_#01, Member of Parliament, Ghana)

"So, we should all contribute; we should all push the parliamentarians, probably their minds are even out of it because those sitting there think that they do not have mental illness. Nevertheless, I think stakeholders need to push harder so that they pass the LI."

(IDI, Municipal Health Insurance Scheme)

Activism by the GMHA and stakeholder community organisations that aimed to put pressure on central Government to prioritise mental healthcare through the provision of resources for effective implementation of the MHA, was considered an important strategy by a number of participants:

"Civil society organisations need to advocate more in order to facilitate the implementation of the MHA. Many people are unaware of the issues about mental health in Ghana; people are even unaware of the existence of the MHA. So, stakeholders need to intensify publicity and education. More importantly, the Government need to prioritise mental healthcare by investing more resources in it."

(IDI, National Health Insurance Scheme)

Similarly, a senior Police Officer and District Magistrate re-iterated the point that there was a need for stakeholder advocacy to ensure Government provided resources to support mental healthcare in Ghana:

"Advocacy. We need to talk about it and engage Government to appreciate the importance of mental health, but now mental health is not an important agenda for the Governments."

(IDI, Divisional Police Commander)

"You know, sometimes people prompt Government to perform specific tasks. People can draw the attention of the Government to focus on some of these essential mental health issues. Therefore, continuous advocacy is the way to go. If we all sit down and do nothing, then the Government will also sit down and do its own thing."

(IDI, District Magistrate)

A representative of an NGO suggested that mental health self-help groups should advocate for better mental health services for their members living with mental illness:

"The mental health self-help groups need to be well organised and strengthened to be able to support each other. Once they are well organised, it is much easier for them to mobilise themselves and advocate for better mental health services such as getting their names registered with the social protection agencies like the National Health Insurance Scheme

(NHIS) or the Livelihood Empowerment Against Poverty (LEAP) programs. They will most likely succeed if they operate as a group than as individuals."

(IDI_#01, NGO)

Another NGO participant considered that NGOs should play ambassadorial roles in promoting the benefits of implementing the MHA:

"I think the NGOs should do more advocacy to ensure that we raise the issue of the need for Government to implement the MHA fully, and if we do not implement it the ramification that is likely to befall us as a nation. We should be able to convince the Government that if somebody will act or behave in a certain way it will start from the mind, so, we should pay more attention to the mind."

(IDI_#03, NGO)

'Advocacy' was a repeated theme for many participants and was considered an important strategy to facilitate the implementation of the MHA. So far, there has been limited publicity of the MHA in Ghana. Creating awareness through vocal advocacy groups about the existence of the MHA is an important strategy to support implementation. A number of participants asserted the need for individuals and groups need to lobby the relevant institutions and advocate through political, economic, and socio-cultural systems to facilitate the needed mental health reform stipulated by the MHA. They further advocated for increased education of the general public about the MHA provisions and their rights and responsibilities under the Act. RMHCs suggested that initiatives, including advocacy by stakeholders to raise mental health awareness, should be taken up at every level of the community. These mental health coordinators pointed to the need for civil society and organised groups to give priority to advocating for mental health reforms:

"At the policy level, there should be an advocacy to ensure that mental healthcare is on the agenda of the Ministry of Health (MoH) and for that matter, the Government. In the communities, they should advocate for the community traditional rulers to take mental health seriously, just like other health conditions. In the church, there should be some level of mental health advocacy to ensure that people are not exhibiting some religious attitudes because they have mental disorders."

(IDI_#05, RMHC)

Similarly, mental health service users were encouraged to form self-help groups to advocate for improved mental health services:

"People with mental illness must be seen to be active in advocating for good mental health services just as their counterparts with physical disabilities do. Service users also need to go out making noise or making their voices heard, I think in our side too, that needed to be done, so the essence of the self-help groups would be that; once they are organised, they are empowered, they have the information, they can also start demanding from Government to ensure implementation of the MHA."

(IDI_#10, RMHC)

Community mental health officers proposed a civil demonstration to compel Government to provide resources to implement the MHA:

> *"All stakeholders must come together and demonstrate against the Government for non-implementation of the MHA. I think the Government of Ghana has ears for demonstrations. Government's ear is always ready to hear demonstrations or hear people agitating. When it happens like that, you see the Government waking up from its sleep. However, until something like that happens, the Government will never listen and pay attention to mental health issues."*

(FGD_#02, Community Psychiatric Nurse)

There is limited media coverage of mental health issues in low-income countries including Ghana (Bird et al., 2011). An NGO representative identified improved media coverage of mental health activities as an important strategy for promoting public awareness of mental health issues in Ghana. This participant stressed the importance of actively involving the media in meetings in which stakeholders were discussing mental health issues, to both publicise and advocate for reform:

> *"Our level of involvement of the media should be at the key stakeholders' meetings where various vital stakeholders have been brought together, at various levels of discussions and consultations. We should engage the media as a critical partner in advocacy to understand the mental health challenges and advocate for us. We have probably not also been able to strengthen the system in such a way that the media also take interest in mental health. Therefore, we have a responsibility to ensure that we involve the media even if the media is not making any efforts to get involved in mental health issues."*

(IDI_#03, NGO)

Integration of mental health in primary care was identified by a number of participants as vital in maximising resources for implementation of the MHA. An RMHC suggested the need for the GMHA to push for full integration of mental health into primary healthcare, to make the best use of the limited resources available for mental healthcare:

> *"The GMHA should push for more mainstreaming of mental healthcare into primary healthcare services. That is the main thing we have adopted in our region. Some people think that the MHA has made mental health services independent, but we need to diffuse these ideas and make sure that mental healthcare is appropriately integrated into primary healthcare to maximise efforts and resources."*

(IDI_#02, RMHC)

Similarly, a representative of an NGO described an elaborate plan by which mental health could be integrated into other national health policies in order to execute the mental health reforms:

> *"We also have to ensure that various opportunities that allow for the integration of mental health are maximised. For instance, we can talk about maternal mental health and why women and gender-based activities should pay attention to mental health. If we take youth development and employment, we should be able to talk about youth mental wellbeing to be able to give up their best. If we take issues of education and we are talking about free Compulsory Universal Basic Education and Free Senior High School, we should be able to think about the mental wellbeing of children and youth who will be going through this so that mental health does not become a stand-alone issue. It can be integrated at various points in various section to have the needed traction that it should or the needed attention that it deserves."*
>
> (IDI_#01, NGO)

A CPO was concerned about the lack of information flow from senior health managers to grass root staff; this was felt to undermine effective coordination. It was suggested that there was a need for more effective communication from policy makers and senior managers to frontline clinical staff:

> *"Yeah, communication and information flow are very important for healthcare delivery. The topmost operational officers, such as the psychiatrists should ensure that they communicate effectively with the frontline health staff in order to enhance the services rendered to patients."*
>
> (IDI, Clinical Psychiatric Officer)

An RMHC commented on the need for healthcare providers to develop their understanding of the MHA, to aid its implementation:

> *"It is suitable for the MHA to be disseminated among health workers, first of all, so that we can then take on the work of educating the general public as well."*
>
> (IDI_#05, RMHC)

Another strategy advanced to expedite implementation of the MHA was to engage mental health service users in paid employment. A mental health service user expressed the view that Government should provide jobs for people living with mental illness who are willing and able to work:

> *"The most important thing is that the Government should engage us in employment opportunities. They should engage us because the Bible even says that the devil finds work for the idled hands. If we are working, we can take care of ourselves and even buy medicine anytime there are none in the health facilities."*

(IDI, Mental Health Service User)

9.3 Mental health education and awareness

Knowledge about mental health and mental illness is limited in Ghana, especially in rural communities (Jorm et al., 2006; Koduah et al., 2019). A participant suggested there is a need to intensify public education about mental health to improve mental health literacy; it was felt this would assist the implementation of the MHA:

> *"Majority of our people in the municipality have no formal education and lack mental health knowledge, and so we have to educate people to know about it. Moreover, behavioural change communication should be intensified to avert the minds of people about mental health. TFHs also need a lot of training and refresher to understand what they are supposed to do and what they should not."*

(IDI, Municipal Director of Health Services)

Education of the public regarding the legal requirements of the MHA was a key theme most participants considered important for implementing the MHA. In discussing the low awareness of the MHA requirements, a key policy implementer considered that inter-stakeholder consultation and collaboration were necessary to improve stakeholder and general community awareness of the statutory requirements, including rights and responsibilities under the MHA:

> *"Most users and carers are unaware of the MHA, its content and the benefits thereof. There is a need to step up education and sensitisation for people to understand their rights and responsibilities under the MHA. Significant stakeholders such as mental health professionals, NCCE, Commission for Human Rights and Administrative Justice, Social Welfare department and all other collaborators need to continually meet and talk about the MHA and how to implement it."*

(IDI, Municipal Health Insurance Authority)

Similarly, an RMHC emphasised the need for mental health education among the public as a strategy to create awareness about the mental health reforms:

> *"Then again, we have to continue education and advocacy. Education is key because people need to be aware that there is a new mental health law, things that were done in the past are no more, things need to be done this way, then there is that change of orientation or thinking, and then gradually we can move towards where we all want to be as a country."*

(IDI_#05, RMHC)

A community psychiatric nurse stressed the importance of educating the SWCD, which is an important Government institution for implementing pro-poor policies to extend services to people living with mental illness:

> *"Personnel of the SWCD have issues understanding the MHA because they are unable to appreciate that some of the people with mental illness can be classified under those with disabilities and should be supported. So, I think that the department should be educated about the MHA and their role in facilitating its implementation."*
>
> (FGD_#04, Community Psychiatric Nurse)

An NGO representative suggested that public education about the adverse effects of stigma and discrimination, as well as policy addressing routine psychiatric assessments, were necessary measures to reduce stigma and discrimination:

> *"I think that we need to have a proper public education program about stigma in languages that people understand. We need to encourage everyone to visit a psychiatrist annually to check their mental status, which should be a policy for the health system. So, stigma will only disappear when there is ongoing public education about the adverse effects of it."*
>
> (IDI_#03, NGO)

Understanding the statutory requirements, roles, and responsibilities under the MHA for first responders is of paramount importance. A senior mental health administrator pointed to the importance of providing further education to the police, who may often be first responders to people experiencing distress from mental ill-health in the community:

> *"We must train the Police personnel because they might be the first to come in contact with persons with mental illnesses who have offended the law. So, we need to train them to appreciate the law, some of the cases they will need to bring to the health facility rather than prosecute them or send them to court."*
>
> (IDI, Senior Mental Health Administrator)

9.4 Training and motivation of mental health workers

Mental health service providers have a high level of responsibility for ensuring implementation of the MHA. Participants considered staff training and motivation to be critical strategies for implementing the MHA. One of the participants considered there should be a strategic initiative by the Government, to attract professionals into the mental health field. Also, the provision of adequate logistics for staff to work, alongside financial incentives, were vital in ensuring the implementation of the MHA:

> *"Strategically, there should be a deliberate effort by the Government to motivate people to go into the mental health field. We need to provide the needed logistics to be able to work because it is not just a department and people; it is about the logistics availability as well. Then, we also need to make sure that we maintain and motivate mental health personnel who are already in the field working."*
>
> (IDI, Municipal Health Insurance Scheme)

Additionally, a senior psychiatrist and an RMHC advocated for specialty training for additional mental health professionals to increase the mental health workforce. According to these participants, the training of multi-disciplinary health professionals would enhance the mental health workforce and contribute significantly to operationalising the MHA:

> *"The Ghana College of Physicians and Surgeons should open training for such specialty areas in psychiatry. The College currently trains professionals in general psychiatry. However, the College should open training for child psychiatry, forensic psychiatry, geriatric psychiatry, addiction psychiatry and others. All these sub-specialties are very useful in improving overall mental healthcare. The college at the start of this training can collaborate with faculties outside Ghana for knowledge transfer. These are the specialties that will continually make psychiatry attractive to young clinicians."*
>
> (IDI_#01, Psychiatrist)

> *"As stakeholders, right now community mental health nurses are being trained to work in the health system, and what we can do further, is to advocate for more specialists to be trained within the health sector. With an appropriate deployment of these critical human resources, I believe the fight for the implementation of the MHA will be more intense."*
>
> (IDI_#05, RMHC)

A CPO commented on political interference in the CPO training programme, which was commenced by the previous Government but suspended by the current Government due to accreditation issues. This participant considered the CPO training program should be strengthened to train more mental health professionals to increase the mental health workforce; the central Government should be committed to ensuring CPO training is streamlined:

> *"The MHA can never be implemented fully unless the human resource base is strengthened through staff training. The Ghana Health Service (GHS) and MoH should formally recognise the CPO training program as an accredited program for mental health professionals' training. The current Government must not be interfering with the CPO training program, which was started by the previous Government. Currently, the CPO training program which was meant to train clinical psychiatric officers had been suspended. When the human resource base is strengthened, it will go a long way for the system to work effectively to implement the MHA."*
>
> (IDI, Clinical Psychiatric Officer)

Similarly, a senior mental health administrator, in commenting on the mental health workforce shortfall, indicated it was strategically important to have sufficient mental health staff appointed and to establish the district mental health sub-committees:

> *"We need to go further into the districts and appoint districts mental health coordinators and districts mental health sub-committees, we need to appoint regional mental health visiting*

> *committees to supervise all places where persons with mental illnesses are kept and treated to ensure that their human rights are being respected. We have also to appoint psychiatrists or clinical psychiatric officers to manage the regional hospitals which are currently being managed by psychiatric nurses. We need to establish mental health review tribunals which will ensure that human rights are respected."*
>
> (IDI, Senior Mental Health Administrator)

Training of sufficient mental health professionals was an important issue discussed by most participants as a strategy to facilitate implementation of the MHA. Two RMHCs discussed the need for Government to honour its legislative responsibility and ensure the right clinical composition of human resource and support agencies as required under the MHA:

> *"We need to ensure that the right mixes of human resources are available for mental healthcare. You know the mental health law states that the GMHA must attract and retain the right mix of human resources. So, the GMHA need to be empowered to attract, retain and fully motivate staff to be able to work well."*
>
> (IDI_#05, RMHC)

> *"There is a need for the Government to ensure that other components such as the regional and district tribunals as well as the visiting committees are all established for effective implementation of the MHA."*
>
> (IDI_#03, RMHC)

One barrier to implementing the MHA (see section 7.8) identified by frontline community mental health nurse participants was the need for the GMHA to give greater consideration of what motivates staff, including remuneration and initiatives to improve workplace health and safety. Expanding discussion of incentives for health workers to practice in psychiatry, a community psychiatric nurse suggested the need for an attractive pension scheme for mental health workers, to entice people to work in the sector:

> *"The GMHA should fashion out an attractive condition of service, including attractive pension entitlements for mental health workers which will attract professionals into the mental health fraternity to support the new mental health reforms."*
>
> (FGD_#01, Community Psychiatric Nurse)

Another form of motivation would be to provide the required resources for staff to work. An RMHC suggested that inadequate resourcing had contributed to mental health professionals becoming disengaged and leaving the service:

> *"The GMHA should address the various concerns of the mental health workforce, which included a lack of resources for work. The lack of resources is demotivating some of the staff who are leaving the mental health sector and joining other departments to work."*

(IDI_#09, RMHC)

9.5 Adequate mental health resourcing

Lack of resourcing has emerged as a major impediment to implementation of the MHA and according to a number of participants, will only be overcome by further investment by the central Government. Mental health services remain centralised in the larger cities in the southern part of Ghana, limiting access to a comparatively small number of people (Akpalu et al., 2010). Participants discussed the need for Government intervention through the allocation of resources and the establishment of additional health facilities across the country, to increase access to mental health services:

> *"Mental health is poorly developed at the community level, and there is still a lot of concentration on the three state psychiatric hospitals, which are also poorly resourced. Government needs to intervene through funding for the expansion of mental health services across all regions in Ghana."*

(IDI_#01, NGO)

As is the case with many countries around the world, mental health reform and legislation in Ghana is strategically focused on establishing mental health as a specialist service within an integrated community-based health model (Ghana Mental Health Authority, 2018). Notwithstanding this, a senior policy implementer questioned the rationale for not constructing more standalone psychiatric hospitals in all administrative regions. This participant added there was also a need to commit resources to improve existing facilities:

> *"Why should someone with acute mental illness in the three northern regions be shipped to Accra or Cape Coast for treatment? The Government should be looking at establishing more psychiatric facilities in all the regions so that patients do not have to travel for long distances to the only three main psychiatric facilities in Accra or Cape Coast. Government needs to commit resources to ensure the establishment of additional facilities and renovate the existing ones so that people with mental illness can be served better."*

(IDI, Municipal Health Insurance Scheme)

Beyond the expansion of mental health facilities, integrated mental health services need to be seen by service users as a better option. A mental health NGO representative discussed the need to make mental health services available, attractive, and more effective than the previous model that was heavily institution-based. For this participant, ensuring conventional mental health services are available and attractive, will motivate people living with mental illness to attend these services:

> *"I think we have to work hard to make mental health services widely available, relevant, and more efficacious than traditional and faith-based centres. Such that if I go to a hospital or a community psychiatric unit, I should see a kind of treatment that will be very different from what I get from the prayer centre, and that will not make it necessary for me to go to a traditional or prayer centre."*
>
> (IDI_#01, NGO)

Participants identified lack of political commitment and leadership to prioritise and invest resources in mental healthcare, as a major barrier to implementation of the MHA. An RMHC echoed the views of other participants who felt it is important that mental health became a national funding priority:

> *"The Government should make mental health a national priority because mental illness is widespread in Ghana. We need political commitment through the provision of adequate funding to ensure that the MHA is implemented. Stakeholders should also focus on prevention strategies through public education."*
>
> (IDI_#04, RMHC)

The importance of Government making mental health a priority was further stressed by a participant from the MoF:

> *"Central Government has to develop more interest and prioritise mental healthcare, and in so doing, allocate adequate funds for implementation of the MHA."*
>
> (IDI, MoF)

A multi-pronged approach was suggested by an NGO representative to address the funding gap for mental healthcare:

> *"We need to hold a dialogue with the MoH and the MoF for consensus building on mental healthcare financing. There is the need for us to continue to advocate strongly, and then we need to get the parliamentary select committee on health to subpoena the Minister for Finance before Parliament to answer why mental health is not funded as the law provides."*
>
> (IDI_#03, NGO)

A senior policy implementer and a community mental health officer, in discussing progress within the regional areas, identified lack of staff transport and inconsistency in psychotropic medication supply, as primary impediments to establishing effective community outreach programs. These participants recapitulated the concerns of several other participants regarding the need for mental health professionals to be provided with adequate resources to ensure successful implementation of the MHA:

> *"We need transport for the mental health team to go on outreach programs; there is only one motorbike in the Kintampo area for that purpose. We will need seven motorbikes to be able to cover all the seven sub-districts in the Kintampo area. We also need to have adequate medication for our patients."*
>
> (IDI, Municipal Director of Health Services)

> *"All we need to work with are the simple logistics such as motorbikes, fuel and medication for mental health service users. The Government should ensure all these are provided to facilitate the implementation of the MHA"*
>
> (IDI, Community Mental Health Officer)

The establishment of a rights-based system is important and needs to be accompanied by the means to exercise those rights. The CHRAJ is a state institution responsible for protecting the rights of citizens through public education and adjudicating on matters of justice for all people. A director of CHRAJ at the municipal level suggested a need for Government to adequately resource the CHRAJ to perform these constitutionally mandated responsibilities:

> *"Educating the public about their civic rights and responsibilities is part of CHRAJ's core role as an institution. However, CHRAJ lacks the necessary logistics such as means of transport to embark on public education, sensitising people about the need to report the abuse and violation of their rights to our offices for adjudication."*
>
> (IDI, Municipal Director, CHRAJ)

In Ghana, mental healthcare, pharmacotherapy, is supposed to be provided free of charge. However, psychotropic medication is generally unavailable in mainstream health facilities, requiring patients to purchase medication from private pharmaceutical shops. The carer of a mental health service user expressed willingness to purchase such medications for their relative, provided the medicines were available in pharmacies. It was considered this would prevent relapse:

> *"We are ready to buy the psychotropic medicine for our patients so long as these medications are available. However, the problem is that there were sometimes these medicines were not available to buy, resulting in patient treatment failure, a situation that defeats the efforts in implementing the MHA to support people living with mental illness."*
>
> (FGD_#04, Carer of Mental Health Service User)

As previously noted, (see section 7.3), inconsistent supply of psychotropic medication in mainstream health facilities is a major issue, with service users often having to purchase prescribed medication from private pharmacies. Recurrent shortages of psychotropic medication have been identified as a significant obstacle to the implementation of the MHA. A

mental health service user stated that mental health should be prioritised to ensure psychotropic medicines are always available for service users:

> *"The Government should ensure that psychotropic medications are always available for people with mental illness. This should be a priority for the Government to ensure that the MHA is implemented."*
>
> (FGD_#01, Mental Health Service User)

As a strategy to reduce dependency on TFHs, the same mental health service user advocated for the construction of community-based psychosocial treatment centres:

> *"Government should establish psychosocial centres in the communities for people with mental illness to seek healthcare. Mostly, we do not know places to seek healthcare, and that is why we go to traditional and faith-based healing centres for treatment."*
>
> (FGD_#01, Mental Health Service User)

The MHA provided for the establishment of a Mental Health Fund to provide a dedicated source of funding for mental health activities. This initiative has not been followed up some nine years since the establishment of the MHA. An RMHC emphasised the strategic importance of establishing such a fund:

> *"Central Government should ensure the establishment of the Mental Health Fund to address the funding challenge confronting mental health service provision."*
>
> (IDI_#08, RMHC)

Another RMHC and a representative of an NGO both pointed to the successful campaigns surrounding HIV/AIDS, maternal and child health and malaria and called for a similar level of Government commitment to mental health reform:

> *"The Government should come out boldly with a complete package for mental healthcare just as is being done for HIV/AIDS and tuberculosis; the same drastic measures such as sponsorship for anti-stigma campaigns on various media platforms should be adopted to tackle mental healthcare. When the Government takes the lead, other stakeholders like the district and municipal assemblies will follow in addressing mental health problems in Ghana."*
>
> (IDI_#06, RMHC)

> *"The MHA can be implemented to the letter if there is a governmental investment, and we make mental health a priority issue in Ghana just as maternal and child health, just as malaria, and then we will be able to reach the level that we all want."*
>
> (IDI_#01, NGO)

A community psychiatric nurse and a social welfare officer called for the GMHA to be adequately funded to support reintegration of institutionalised and often itinerant mental health service users into supported community care and the establishment of community shelters as rehabilitation centres:

> *"We have to take people with mental illness off the streets and reintegrate them with their families; this will directly reduce stigma and discrimination. The GMHA should be adequately resourced to operate so that it can implement these provisions which are included in the MHA."*
>
> (FGD_#01, Community Psychiatric Nurse)

> *"The State needs to construct shelters to accommodate all people with mental illness roaming the streets. These shelters can serve as rehabilitation centres for the training of recovered patients for reintegration into society. The communities should also be educated to accept these people back to society."*
>
> (IDI, Municipal Social Welfare and Community Development)

9.6 Collaboration with and regulation of TFHs

Conventional mental health practitioners and TFHs can work together in a collaborative effort to improve healthcare delivery for people living with mental illness. Although collaboration has been recommended in global mental health policy as a strategy for preventing human rights abuse, it is not clear how such collaboration could be established (Read, 2019). Nonetheless, research in Ghana and Nigeria regarding a collaborative shared care model for helping people with psychosis, delivered by both conventional mental health service providers and TFHs, was evaluated as being safe and cost-effective (Gureje et al., 2020); in effect, maximising the resources available for mental healthcare delivery. Some participants in the current study discussed at length the need for collaboration between conventional mental health service providers and TFHs:

> *"There should be an effective collaboration between orthodox mental health practitioners and TFHs so that while patients are in the custody of faith-based healers, mental health workers are allowed to visit such persons from time to time to assess patients' physical needs."*
>
> (FGD_#01, Community Psychiatric Nurse)

The MHA has formally recognised TFHs as mental health service providers. A senior mental health administrator reiterated the need for further collaboration to ease the tension between conventional mental health service providers and their TFH counterparts:

> *"Another thing that we also would be proud of is the recognition of TFHs as "frontline informal community mental health workers". This recognition will ease the tension between conventional health service providers and TFHs and promote harmony for co-existence."*
>
> (IDI, Senior Mental Health Administrator)

A community psychiatric nurse narrated the benefits of collaboration between conventional mental health service providers and TFHs. This participant considered the need to educate TFHs further to collaborate with conventional mental health service providers to provide holistic and integrative health services:

> *"We have to educate all the TFHs to appreciate the need to collaborate with mental health service providers. For instance, there is one prayer centre located in the Central Region that collaborates very well with the health facilities in caring for people with mental illness. Whenever someone comes there with a mental health problem, the first point of contact is the mental health officer for screening. Periodically, patients are taken to the hospital for review. Patients are permitted to take medication while receiving spiritual healing. So, that prayer centre leader understands the importance of medication for people with mental illness."*
>
> (FGD_#02, Community Psychiatric Nurse)

The importance of the current and future role of TFHs was acknowledged by an RMHC, emphasising the need to develop the capacity of these practitioners to perform their roles without violating patients' rights:

> *"Yes, another way is to develop the capacity of TFHs to understand the signs of common mental disorders so that they will be able to manage patients accordingly. Yes, education, capacity building, and empowerment is the way forward. Knowledge of the different types of mental illness may change their attitudes towards the inhumane practices of chaining or caging patients."*
>
> (IDI_#09, RMHC)

Some participants suggested the need for an integrative practice model for incorporating TFHs into contemporary mental healthcare and regulating their activities. The development of protocols and guidelines by the GMHA to regulate the practice of TFHs was described as an effective strategy that would facilitate the implementation of the MHA (Ghana Mental Health Authority, 2018). The expectation is that these guidelines will help prevent human rights abuses in the traditional and faith-based healing centres:

> *"We have developed some protocols and guidelines; healthcare providers will be training TFHs to understand what they should do and what they should not do when dealing with people living with mental disorders."*
>
> (IDI, Senior Mental Health Administrator)

A community mental health officer stated that stakeholder collaboration, especially with the alternative mental health service providers such as TFHs, would encourage implementation of the MHA:

> *"There will be a very smooth implementation of the MHA if the health sector gets on board the significant stakeholders such as pastors, fetish priests, faith-based healers, and Muslim healers or Imams. Can you imagine when all the pastors begin to invite mental health professionals to talk to their congregation about mental health issues and faith-based healers or pastors adding their voices to the effect that mental illness is not spiritual but can be treated at the health facilities? This collaboration will go a long way to improve overall mental healthcare delivery in the country."*

(IDI, Community Mental Health Officer)

An RMHC advocated for the trial GMHA training program for TFHs to be rolled out nationally to improve the capacity of faith healers to manage people living with mental illness. It was felt this training, which included the distribution of registers, would promote good record keeping at the faith-healing centres:

> *"The GMHA has started training TFHs about how to manage people with mental illness at the camps and also sensitising them about the MHA. This training should be formalised throughout the country to ensure more comprehensive coverage. We have started also giving out some registers to the TFHs to register all people seeking help from their camps. This too needs to roll out nationwide to improve documentation and will also serve as a way of regulating activities that go on at the various camps, so that when you visit these camps as a mental health worker, you can access the register to see what interventions have been taken for patients."*

(IDI_#02, RMHC)

A number of RMHCs in discussing the importance of collaboration, also noted the importance of sensitising TFHs to the limitations of their practice within an integrated care model. These coordinators further emphasised the need for TFHs to receive education into what constitutes human rights violation. The views are voiced by an RMHC:

> *"Sensitising and educating TFHs about their limitations in managing patients is important and in progress. This was what we were doing during our collaboration; we tried to sensitise them to understand their limits, what they can do and what they cannot do to avoid or minimise violation of patient's rights. So, those are the issues we are looking to address in the future."*

(IDI_#09, RMHC)

A representative of a municipal health insurance authority considered that all stakeholders, including community members, should be educated about mental health and the need for them to report violations of patients' rights to the appropriate authorities:

> *"As a process, we need to educate the leaders of traditional and faith-based healing centres about the importance of protecting the rights of people with mental illness. TFHs must know what to do and what not to do when caring for patients. Furthermore, the community members*

should be educated and encouraged to report TFHs whose practices violates the rights of patients to the appropriate bodies."

(IDI, Municipal Health Insurance Authority)

A Member of Ghana's 7th Parliament and a Social Welfare officer both supported the need to develop the capacity of TFHs and to regulate their practices to minimise violation of patients' rights. These participants went on to argue that understanding of the legal requirements of the MHA would help prevent inhumane treatment, such as denial of food and chaining or shackling of patients, in traditional and faith-based healing centres. It was also suggested that collaboration between the department of Social Welfare and Community Development and mental health workers would ensure the interests of patients were always protected:

"One of the measures to improve mental healthcare delivery and reduce human rights abuse is to have legislation to try and regulate the way TFHs do their job. This is because technically, once TFHs see mental health patients, they are just like health facilities, so, they should be appropriately regulated when they are handling these patients. There should be a collaboration between the GHMA and the TFHs so that they can educate these healers, give them some refresher training, capacity building for them to understand how best to manage patients that visit them for mental health services."

(IDI_#01, Member of Parliament, Ghana)

"TFHs need to be educated about the MHA, for them to understand that people with mental illness have some rights which should be respected. Some patients are customarily tasked to fast 30 to 40 days or chained to trees because they are agitated. These practices must stop through regular supervision. The Social Welfare workers also need to collaborate with mental health workers to protect the rights of patients at all times."

(IDI, Social Welfare and Community Development)

Another strategy identified to facilitate implementation of the MHA was the use of influential public figures to advocate against mental illness-related stigma and discrimination. A participant suggested the need to adopt an assertive approach involving the use of respected community members and role models, or 'big stars', as ambassadors to ensure stigma and discrimination were addressed:

"From my perspective, to reduce or end stigma, I think we need to use aggressive education, using stars and courageous leaders, traditional rulers and other people as ambassadors to raise awareness. We can use behaviour change communication; speaking to people using ambassadors, advocates, persons with lived experiences who are making it in their field of endeavours, volunteers and role models who are well known in the society to talk about stigma and mental illness."

(IDI_#05, RMHC)

In relation to the issue of reducing stigma and discrimination, a participant from the MoF called for a comprehensive community education program:

> *"To fight for a reduction in stigma and discrimination against people with mental ill-health, the health authority will have to continue educating community members including healthcare providers to change their attitudes towards people with mental health issues."*
>
> (IDI, MoF)

Both a Muslim spiritual healer and a CPO emphasised the need to educate TFHs who were abusing the rights of people living with mental illness:

> *"Well, I think education is a key; we educate the people involved in this kind of malpractices, we tell them that beating the patient, locking, shackling, or chaining the patients is against their rights and will not also heal the patient. Instead, these patients should be handled with good care."*
>
> (IDI, Muslim Healer)

> *"TFHs are relevant stakeholders in mental healthcare, and we need to educate them on how they manage patients without infringing upon their rights. This is because some people prefer to go to these healers rather than go to the various psychiatric health facilities for treatment."*
>
> (IDI, CPO)

A clinical psychologist outlined a strategy to educate TFHs on ways to collaborate with conventional mental health service providers, for the management of agitated patients in faith-based healing centres:

> *"Some of TFHs are unaware that practices such us chaining and caging are abusive and against the rights of patients. As a strategy for containing agitated patients, TFHs should be advised to invite a mental health worker to the camp to help manage such patients before they can continue their spiritual healing."*
>
> (IDI, Clinical Psychologist)

Apart from education of the public about mental health and the need to protect the rights of services users, participants also discussed the importance of the legal requirements of the MHA being enforced. Implementation of proven interventions, such as mental health legislation, remains inconsistent in low resourced countries (Lund et al., 2011). In Ghana, previous mental health policies have not been implemented (Awenva et al., 2010; Doku et al., 2012). The participants considered that enforcement of the MHA, including punishing offenders, was key to its implementation. A municipal director CHRAJ commented that some violations of human rights occur out of ignorance, hence the need for public education about and enforcement of the provisions of the MHA:

> *"Maybe if people are seen to be punished when they contravene the law, I think it will go a long way to deter other people from perpetrating some of the MHAs that violate the rights of people with mental illness. Public education is vital because I know that some of the time, people violate the rights of patients ignorantly. Enforcement of the law is critical for safeguarding the rights of people with mental illness."*
>
> (IDI, Municipal Director, CHRAJ)

An RMHC considered that community-based mental healthcare must be prioritised and enforced, as doing so is cost-effective and reduces stigma and discrimination against people living with mental illness:

> *"Yes, my suggestion is for us to look towards the direction of community mental healthcare since that is what the law proposes. Yes, scholars have identified that community care is not cost involving as compared to institutionalised care. It will also do away with stigmatisation; it empowers the patient family to own and take care of the patient. It also takes away the superstitions that people have about mental illness. So, we are hoping that policymakers and implementers will all look towards supporting and pushing for community care to be strengthened, and when we do that, we will be able to achieve tremendous success. The provisions in the MHA must be legally enforced to achieve its objectives of improving mental health services."*
>
> (IDI_#09, RMHC)

A community opinion leader, in acknowledging the legal status of mental health visiting committees as independent monitors, called for the committees to monitor and report on the activities of TFHs:

> *"The MHA prescribes that there should be mental health visiting committee with the responsibility of monitoring the activities of the faith-based camps. So, in every district, there is supposed to be a visiting committee that will periodically pay unannounced visits to these faith-based camps to ensure that they are complying with the dictates of the law. Those found to be working contrary to the law are outlawed or brought to the mental health tribunal, which is also supposed to be set up for this purpose."*
>
> (IDI_#03, NGO)

However, a medical superintendent acknowledged the difficulty in regulating the activities of all TFHs, and called for a more punitive approach:

> *"TFHs should be well regulated, but we all know the difficulty in regulating a one-man church or pastor who is operating somewhere in the bush, it becomes a difficult one. However, if these healers are proper and not just some mushrooming people, then, it should be possible to work with them. As for abuse in any form, whether it is with mentally ill patients or with other vulnerable groups or even with ordinary people, it is wrong in all aspects. The challenge is how to identify those people who are going beyond their bounds and putting them before the courts or allowing justice to prevail for those abused."*
>
> (IDI, Medical Superintendent, Municipal Hospital)

9.7 Access to psychotropic medicines

For people with mental ill-health, treatment with antipsychotic medication is a key aspect of care to relieve acute symptoms and distress. Access to psychotropic medicines requires coordinated effort involving different levels to match demand. The NHIS (National Health Insurance Act, 2003) was introduced in Ghana in 2003, as a safety net to ensure all Ghanaians have access to basic health services. Under the NHIS Act, people living with mental disorders are entitled to register and receive NHIS services free of charge once they are assessed as indigents. However, the scheme provides minimal coverage for accessing mental health services, as the scheme does not pay for the cost of psychotropic medicines (Agyepong & Adjei, 2008). The importance of psychotropic medications being provided under the NHIS was discussed by various participants as a strategy to improve supply. Provision of psychotropic medication does not currently fall within the scope of the NHIS as such medicines are supposed to be procured by Government for patients free of charge. However, these medicines are always in short supply. The following quote represents the views made by a number of RMHCs to the effect that the National Health Insurance Authority (Igbinomwanhia et al.), which manages the NHIS, should take over responsibility for procurement to ensure regular supply of these medications:

> *"To mitigate the financial problems responsible for the periodic shortages of psychotropic medication, the Government needs to take steps to ensure that mental health services are rolled onto the NHIS so that the cost of mental health services can be catered for, and the bills paid by the NHIA. In this case, the health facilities will have enough funds to run the facilities so that they do not have to depend on Government funds to procure medication."*
>
> (IDI_#05, RMHC)

Further to this, a participant from the NHIA discussed what were considered to be perplexing relationships and funding responsibilities involving the MoH and the NHIA, on the one hand, and service users on the other hand. What was needed, according to this participant, was a carefully constructed approach for the procurement of major psychiatric medications:

> *"We have engaged the MoH to always release the money meant for the procurement of psychotropic medications for people with mental illness to the NHIA to procure these medicines and provide free mental health services to patients. The NHIA is also challenged with funding and therefore in discussion with the MoH to resolve the issue of rolling on the cost of mental health services to the NHIS. I will suggest that the MHA is amended to remove the "free" aspect of mental health services from it so that people with mental illness can be enrolled on the NHIS."*
>
> (IDI, National Health Insurance Authority)

A senior psychiatrist considered that the cost of mental health services should be covered by the NHIS as an alternative source of funding. It was also proposed that the NHIS levy be increased to take account of the cost of mental health services:

> *"It has been very difficult to set aside a special levy for mental healthcare even though provided for in the MHA. I will advocate that the NHIS levy should be increased by a certain minimum percentage point to cover mental health services, just like other communicable and non-communicable health conditions. Thus, we would have some form of reimbursement by the NHIS for mental health service delivery."*
>
> (IDI_#02, Psychiatrist)

A psychiatrist and a representative of an NGO both suggested mental health service users should be expected to contribute to the cost of mental health services, especially those wishing to access a premium service; it was felt such a contribution through direct payment could offset any shortfall in Government funding for mental health services. This would allow private participation in mental health service delivery:

> *"Making money available to ensure that mental health service is improved, and people get a certain quality of care means that people who need to have some premium service and pay value for money should be allowed to pay for this service. This may encourage private health insurance providers to get on board to promote quality mental healthcare. So long as mental health service is free by policy, no insurance company would like to invest in that area."*
>
> (IDI_#02, Psychiatrist)

> *"I think that the users of psychiatric services should also make some small contribution to pay for service delivery. Of course, in every society, we will have people who cannot afford at all. Whatever you do they will not be able to pay, those are separate people we can categorise them, make room for them in terms of service provisions, but generally, I think that service users should begin to contribute something small, very small, and then highly subsidise by Government."*
>
> (IDI_#03, NGO)

9.8 Stakeholder engagement

Stakeholder engagement for advocacy was identified as an important strategy to support implementation of the MHA. Participants discussed the need for broader consultation and engagement among stakeholders to facilitate the implementation of the MHA. Reinforcement of collaboration between the GHS and the GMHA was considered a significant strategy to facilitate implementation of the MHA. An RMHC suggested that to ensure decentralised mental healthcare, there was a need to strengthen collaboration at the lower level of healthcare delivery; so mental health is visible at the primary healthcare level:

> *"The focus of the MHA is deinstitutionalisation, yet little attention is directed at the districts or regional level. The health authorities need to do more collaboration with the GHS at the lower*

> *level so that mental health is seen as part of the general healthcare delivery setup. Currently, mental health is operating parallel to the GHS, which is not good enough for coordination."*
>
> (IDI_#02, RMHC)

The MoH is responsible for developing health policies in Ghana. The GMHA is one of twenty-five agencies under the MoH, responsible for overseeing policy implementation. Further, the GMHA is responsible for ensuring quality mental healthcare at a service provider level, including working in partnership to integrate mental health services into the general healthcare sector. The importance of this partnership was further highlighted by another RMHC:

> *"I suggest the GMHA should integrate properly with the GHS. The GMHA needs to create that professional alliance or relationship with the sister MoH agencies such as the GHS so that when the state allocating national resources, the GMHA as an agency will not be left out."*
>
> (IDI_#07, RMHC)

A municipal director further emphasised the importance of strategic relationship building between the GMHA and the GHS, to ensure easy access to primary mental healthcare across regional and rural communities:

> *"There is a need for the GMHA to engage more with the GHS to ensure easy access to primary mental healthcare services. GHS has several health facilities dotted everywhere around the country and should be given the responsibility of integrating mental health services in its health facilities to increase access, especially in rural communities."*
>
> (IDI, Municipal Director, NCCE)

An NGO participant noted there should be clearly delineated reporting lines for mental health staff, to overcome role conflict and confusion between the GMHA and the GHS and to protect against inter-organisational tension:

> *"The GHS and the GMHA are both health agencies under the MoH. These two agencies should work together so that services are provided to all patients, and they should not think about who is dominant over the other. The GMHA is responsible for setting standards and ensuring that standards are adhered. The GHS is supposed to deliver the services according to standards set out. The confusion about who own the community psychiatric nurses and whom these nurses should report to should be streamlined and resolved quickly for effective coordination."*
>
> (IDI-#01, NGO)

Moreover, participants commented on the importance of intersectoral collaboration among stakeholders, advocacy, resourcing and improving the capacity of mental health professionals; these were seen to be important to the effective implementation of the MHA:

> *"We need to collaborate with other people and organisations that have resources to promote mental healthcare. The NGOs, benevolent groups, international donors are all there for collaboration. Attention must be focused on mental health just as we do for breast cancer awareness, malaria, HIV/AIDS, diabetes, and others."*
>
> (IDI, Community Mental Health Officer)

Ghana has a complex political system split between the elected executive of Government and traditional chiefdoms. Chiefdoms in Ghana constitute a traditional political organisation characterised by social hierarchies and consolidation of political power at a local level. Local community leaders such as chiefs and assembly members are respected leaders and hold considerable power and influence within their communities (Kirst, 2020; Marfo, 2019; Stoeltje, 2019). It was also considered these important community leaders should be mobilised to engage with and promote implementation of the MHA:

> *"The chiefs, the assembly members and those who hold position within the community level should be given detailed information about the MHA so that they will be able to cooperate and encourage their subjects to promote mental health. When these leaders are well informed about mental health, they can even give orders to people living with mental illness to be taken to the health facility for treatment."*
>
> (IDI_#06. RMHC)

An NGO worker identified the importance of the GMHA leading a national strategy on mental health, bringing all Government and non-government stakeholders together to set a clear strategic pathway for implementing the legislated mental health reforms:

> *"The way forward for the implementation of the MHA is for all stakeholders to work together, viewing mental health as part of monitoring the healthcare system that we have in the country. Again, I think that all stakeholders need to get together to dialogue on sustainable funding for mental healthcare, and the GMHA should lead the process. We should also try as much as possible to increase public awareness about the state of mental health in the country. People should take an interest in reading the various disability and mental health legislations that we have in the country to understand the issues surrounding mental health."*
>
> (IDI_#03, NGO)

Further to this, a senior psychiatrist suggested there should be clear definition of the roles of all mental health stakeholders, to ensure effective implementation of the MHA. This was deemed necessary as some stakeholders appeared unaware of the MHA and there was an urgent need to protect the rights of service users:

> *"As spelt out in the MHA, we have to define the role of every stakeholder clearly. We also give clear demarcation of what anybody in the traditional and faith-based institutions can do regarding the provision of mental health service, not keeping persons who are a risk to themselves or others, or not keeping people involuntarily and necessitating chaining, fasting, beatings which constitutes human rights abuse that we are all fighting against."*
>
> (IDI_#02, Psychiatrist)

This was also seen to be important by a community mental health nurse:

> *"What I will add is that we have to educate all relevant partners about their roles and responsibilities as stipulated in the MHA so that when we go to them as mental health nurses, they will know what they are supposed to do so that our work will be much easier."*
>
> (FGD_#04, Community Psychiatric Nurse)

An RMHC emphasised the significance of engaging partner organisations in mental health and various social protection agencies to assist in the provision of social protection programs for people with mental ill-health:

> *"We need to engage the various social protection agencies such as the Prison Service, Social Welfare, the National Disaster Management Organisation (NADMO), the Police Service and CHRAJ so that we will be able to enhance social protection programs for people with mental illness."*
>
> (IDI_#09, RMHC)

There is a lack of understanding among some individuals and agencies that people with chronic and enduring mental illness could be classified as disabled under the Persons with Disability Act. Raising awareness of this within the department of Social Welfare and Community Development was considered important, so that eligible individuals with mental illness could be registered to access benefits under the LEAP program:

> *"I think it needs a lot of advocacies, stakeholder's engagement to understand that mental illness could be a form of a disability. In the past, people did not know that some mental illnesses could be a disability. It is now that the awareness is coming up, and so, some people with mental illnesses are currently being registered onto the LEAP program."*
>
> (IDI_#05, RMHC)

A participant from the Municipal Health Insurance Scheme emphasised the importance of the GMHA working with the non-clinical services responsible for funding and supporting welfare services:

> *"There should be a collaboration between the GMHA and all other major stakeholders such as NCCE, NHIS, Social Welfare, Municipal and District Assemblies for them to understand why they should all commit resources into the MHA implementation."*
>
> (IDI, Municipal Insurance Authority)

A clinical psychologist whilst acknowledging the importance of strategically engaging with the general healthcare sector, identified the need for greater intra-mental health sector coordination and advocacy by specialist mental health service providers:

> *"There should be an effective high-level collaboration between the mental health outlets in the municipality to attract funding for mental healthcare. Here we have about three units that provide mental health services aside from the peripheral units at the health facilities. We need a coordinated effort in sourcing funding to fund mental health activities in the municipality."*
>
> (IDI, Clinical Psychologist)

A community mental health nurse highlighted the importance of multi-sectoral leadership and advocacy to pressure the Government to provide adequate resources to enable integration of mental health services:

> *"I am of the view that there should be a strong coercion team from all the stakeholders to mount pressure on central Government to provide resources for the implementation of the MHA. So, all the key stakeholders, including religious institutions, should all come together as a pressure group to dialogue with Government to provide resources for mental health services."*
>
> (FGD_#01, Community Psychiatric Nurse)

Similarly, a representative of the SWCD department stressed the need for advocacy by all key stakeholders for the Government to prioritise mental healthcare by providing adequate resources for implementation:

> *"I will say that for the MHA to be implemented successfully, all stockholders such as Social Welfare, health service providers, Police Service, religious bodies and others should unite and lobby the Government to put in the needed resources towards the implementation of the MHA. The Government should establish the various mental health committees at the regional and district level to supervise the implementation of the MHA."*
>
> (IDI, Municipal Social Welfare Director)

A community mental health nurse criticised the Government's centralised attitude and called for a decentralised and more inclusive approach to consultation to streamline implementation of the MHA:

> *"At every stage of the implementation of the MHA, the authorities should not only sit in Accra as experts and fashion out things that may not work at the lower level. The authorities must*

involve us in decision making process so that we can collectively agree on workable solutions to implementing the MHA."

(FGD_#01, Community Psychiatric Nurse)

As in many low to middle income countries, the prevailing public health agenda has taken priority over mental healthcare (Benedetto Saraceno et al., 2007). Therefore, as is the case in many countries around the world, NGOs in Ghana play a major role in supporting mental health services because of the low priority given to it by Governments (Cohen et al., 2012; Raja et al., 2010). A clinical psychologist asserted the need for the Government/NGO sector relationship to be strengthened in mental healthcare:

"We need to work closely with the NGOs to continue to fund some of our activities, and not rely on only the Government. Some of the NGOs are supporting with medication for our patients, but we will need more support, including sponsorship for radio engagement to educate the public about mental health and the MHA."

(IDI, Clinical Psychologist)

9.9 The MHA LI

Legislative instruments are laws on matters of detail such as regulations, rules and determinations made by a body authorised to do so under a relevant Act of Government (Local Governance Act 936, 2016). The MHA in Ghana was passed into law in March 2012. However, there was a delay of several years in passing the necessary LI. Participants considered that non-operationalisation of the LI for the MHA was a stumbling block to the effective delivery of mental healthcare services. The delay in passing the LI was seen by various participants as a serious impediment to implementing the MHA. Suggested strategies for expediting the passage of the LI included stakeholder advocacy. This was considered essential to establish a funding base to support implementation of the MHA:

"We, as key stakeholders need to push until we get the LI passed, and the mental health levy established. If we have the levy established, and we have money flowing from central Government, a lot of the mental healthcare challenges will be resolved. So, that to me should be our emphasis and focus as key stakeholders. We need to continuously keep on reminding central Government so that we will be on the front burner; otherwise, we tend to be relegated."

(IDI, Senior Mental Health Administrator)

"We have to engage civil society, try to lobby with those in authority, the influential people like the Parliamentarians, to explain to them the reasons why the LI should be passed, and once they also have this understanding, I think they will facilitate the process leading to the passage of the LI."

(IDI_#06. RMHC)

A number of participants also made the point that passing the LI would go some way to addressing the problems of mental health underfunding. This was considered an important first step towards the implementation of the MHA as it was thought this would resolve the problem of mental health underfunding. A legislator summed these views:

> *"I believe that the passage of the LI will close a huge funding gap and allow the implementation of the MHA so that persons with mental illness can be heard in our society and their needs considered in the national dialogue."*
>
> (IDI_#02, Member of Parliament, Ghana)

9.10 Chapter summary

This chapter has reported the findings of qualitative interviews with key stakeholders addressing strategies and enablers for facilitating implementation of the MHA. There has been slow implementation of the MHA since its introduction in 2012. The main reason identified by participants for slow implementation of the MHA was lack of political commitment to provide the necessary resources. The research participants discussed the following themes as potential enablers to fast-track the implementation process: research and advocacy, mental health awareness, staff training and motivation, provision of adequate resourcing, regulation and collaboration with TFHs, the role of NHIS, key stakeholders' collaboration; and the need to pass the MHA LI.

Advocacy, provision of adequate funding and collaboration with stakeholders were the most frequently cited themes discussed by participants, as contributing to the slow implementation of the MHA. Participants were unanimous that all key stakeholders and partners including the Ghana Police Service, Prison Services, Social welfare, NHIA, GHS, CHRAJ, and TFHs needed to work in a coordinated effort to progress implementation of the MHA. Stakeholder advocacy and activism were considered critical strategies for compelling Government to commit resources to mental healthcare. There has been a longstanding lack of interest and commitment to mental health in Ghana (Awenva et al., 2010; Doku et al., 2012; Roberts et al., 2014). The importance of the central Government prioritising and committing more resources to mental health was considered essential for the successful implementation of the MHA. So far this had not been evident. The lack of resources had been experienced by mental health practitioners in the field in the non-availability of motor vehicles and motorbikes for community outreach and the inconsistent supply of psychotropic medications. These were considered major setbacks for the implementation of the MHA.

If frontline mental health service providers discussed the need for central Government to provide adequate resources, policymakers and community opinion leaders were concerned about key stakeholder collaboration, training of appropriate staff, as well as the building of

mental health awareness as initiatives for promoting the implementation of the MHA. Participants argued that the widespread lack of awareness of the MHA, coupled with misconceptions regarding mental illness, pointed to a need for systematic public education to improve mental health literacy and ensure penetration of the MHA.

A major focus for policymakers and community opinion leaders was the need for mental health research that would provide data to support calls for the implementation of the MHA. It was felt such research data would bolster demands for central Government to make a much greater investment in mental healthcare.

Mental health service providers discussed the importance of regulating the practices of TFHs and ensuring passage of the LI to establish a MHA levy, to guarantee funding for mental healthcare in Ghana. There was also a high level of agreement among participants that the provisions of the MHA should be enforced, and breeches of those provisions punished. There was general support for conventional mental health service providers working collaboratively with TFHs to reduce human rights abuses and increasing access to mental healthcare. The delay in passing the MHA LI was considered a significant impediment to the implementation of MHA. Passage of the MHA LI was identified as an important priority to enable establishment of a mental health fund.

Participants also discussed the importance of the NHIS being extended to include mental illness. Currently, the NHIS does not include treatment for mental illness as under national law, this is meant to be provided free of charge. A number of participants expressed the view that including mental health services under the NHIS may resolve significant problems such as shortages of medication for people living with mental disorders. It was also felt this would encourage private sector participation in mental health, by bringing health insurance schemes into the field.

Chapter 10 presents the role of mental health stakeholders towards implementing the MHA.

Chapter 10 Role of mental health stakeholders in implementing the MHA

10.1 Introduction

Chapter 10 presents evidence from a qualitative study that explored the role of key mental health stakeholders and agencies towards implementation of the MHA. The MHA includes provisions for the creation of a modern, community-based mental health system and for the protection of the rights of persons with mental disorders. Since the MHA introduction, implementation of the statutory requirements has been slow, and concerns have been raised that focus on the expedient role and responsibility of corporate agencies and key stakeholders. The stakeholders who participated in this study included senior civil servants, health professionals, law enforcement officers, parliamentarians, community opinion leaders, non-government organisations (NGOs), mental health service users, carers, and TFHs. Participants described what they considered to be the role of key mental health stakeholders towards implementing the MHA and further highlighted the challenges impeding progress of mental healthcare in general.

This chapter begins by presenting what the study participants identified as the general roles expected to be performed through multi-sectoral collaboration to support the implementation of the MHA and anticipated changes in mental healthcare delivery. This is followed by a section that discussed the role of Government social intervention schemes and how these policies have impacted on the lives of people living with mental illness. The roles of other key stakeholders such as those working in the legal and security institutions, NGOs, community opinion leaders, mental health service providers, service users, carers, and local Government Assemblies towards the implementation of the MHA are discussed. Throughout the chapter, quotes from the interview transcripts are provided to corroborate the views expressed by the study participants. The chapter concludes with a section on a summary of key points discussed by participants in relation to the roles played by stakeholders in implementing the MHA.

10.2 Multi-sectoral collaboration

A number of participants expressed the view that every individual has a role to play towards delivering mental healthcare. Mental health is everyone's business, and therefore all individuals and cooperate bodies have a role to play to promote the implementation of the MHA and legislative requirements. A RMHC explained:

> *"As individuals, we all have a role to play. Mental health service users, for instance, have to know the things that they are entitled to; the rights that they have, and the role they can also play to promote a mentally healthy society. Some of the service users have even formed self-help groups to support each other, which is good. We know in our various localities, especially in the rural areas we revere our chiefs and the religious leaders, so these people can also use their platforms to sell mental health information to the public to increase public awareness about mental health issues. I think all of us would need to play role to promote good mental health. For instance, the security services should be able to help stop the abuse of the rights of people with mental disorders."*
>
> (IDI_#08, RMHC)

One of the RMHCs suggested multi-sectoral collaboration as a collective approach to achieve the common purpose of supporting mental health reform nationally. According to this participant, traditional authorities, NGOs, and civil society organisations have been part of the struggle for better mental health service provision for people living with mental illness. These key stakeholders should continue to perform an advocacy role to facilitate the implementation of the MHA:

> *"It took a multi-sectoral effort that included NGOs and civil society organisations, chiefs, opinion leaders and others to push for the passage of the MHA. After passing the MHA, their role is still crucial as far as advocating for the implementation of the MHA. Chiefs hold power in our local areas and so, we have engaged chiefs through durbars where we talked about the need to abolish the use of chains on people kept in traditional and faith-based centres. Issues of stigma and discrimination are still rife in our communities, and it will take chiefs and NGOs to speak up for these things to change. Even with the legislative instrument that is yet to be passed, it will take chiefs, local authorities and NGOs to speak up and advocate for central Government to prioritise mental health."*
>
> (IDI_#07, RMHC)

The importance of multi-sectoral collaboration and intervention in facilitating the implementation of the MHA cannot be over-emphasised. It is clear that mental health is not just a 'health matter' but has 'social' implications as well (Doku et al 2012). As discussed in previous sections (see sections 2.5.2 and 7. 2), the financing of mental health care should not be the sole responsibility of the MoH, instead there has to be some formal collaboration between the Ministries of Finance, Employment and Social Welfare and Local Government as

these Ministries have core responsibilities and interests in the provision of mental health (Doku et al., 2012; Walker, 2015).

10.3 District Assemblies

Decentralisation of administration to District Assemblies provides for Government policy and legislative requirements to be directly implemented at a local level (see section 1.2.1). A number of participants discussed the role of the District Assemblies in promoting mental health reforms. One of the Assemblies' critical responsibilities under the MHA is to ensure people with mental illness are provided with the necessary treatment and support to reintegrate into society. This presents as a challenge for many District Assemblies due to inadequate funding. An RMHC observed:

> *"The District Assemblies are responsible for ensuring that they make budgetary allocation to support care and reduce vagrancy amongst people living with mental illness. However, this remains a challenge for the Assemblies due to inadequate resources, including lack of shelter to accommodate homeless people. A number of Assemblies have started to address the issue of vagrancy, albeit lack of funds has prevented them from having a meaningful impact."*
>
> (IDI_#08, RMHC)

A local Government inspector and an RMHC confirmed that the District Assemblies are responsible for ensuring that vagrant mentally ill are offered treatment, rehabilitation and safe accommodation, while further highlighting the financial challenges faced by these Assemblies:

> *"District Assemblies have the ultimate responsibility for ensuring that people with mental illness roaming the streets are taken off and accommodated, but there are no funds to ensure that is done. The social protection agencies are also inadequately funded to take care of the needs of these patients on the streets."*
>
> (IDI, Municipal Local Government Inspector)

> *"The responsibility lies in the district and regional coordinating Assemblies to team up with the Police and the social welfare department to take people with mental illness off the streets for treatment."*
>
> (IDI_#01, RMHC)

It was felt that the District Assemblies should invest more in constructing accommodation for people living with mental illness who are vagrants and unable to adequately support themselves. The DACF is a formula-based system of financial transfers for local development from the Central Government. A Municipal Director of the National Health Insurance Scheme (NHIS) argued for a percentage of the Fund to be directed to provide treatment and accommodation for people with mental illness who are vagrant. This participant further

observed that providing accommodation for this vulnerable group will facilitate close contact with them to provide more supportive treatment:

> *"The District Assemblies should invest part of its DACF to construct accommodation for the mentally ill living on the streets. We should be moving towards a point where we can provide decent accommodation for them."*
>
> (IDI, Municipal Health Insurance Authority)

The inclusion of the Mental Health Fund under the MHA was to provide financial resources for the care and management of persons suffering from mental disorders. Government's inability to establish the fund was considered a barrier to the District Assemblies' failure to perform their roles effectively. A senior psychiatrist indicated:

> *"The District Assemblies through the Department of Social Welfare and Community Development (SWCD) is supposed to provide funding under the DACF to persons found within their jurisdiction to ensure that they get the needed help through mental health practitioners' expertise within the district or outside if the need is for them to be transferred to higher institutions. However, there are challenges with this provision because of the partial implementation of the MHA, which is due to the absence of the mental health fund."*
>
> (IDI_#02, Psychiatrist)

10.4 Government social intervention policies

Participants identified two main social intervention policies instituted by the Government of Ghana to support people who are less privileged. These are the LEAP) programme which is under the supervision of the department of SWCD, and the NHIS under the stewardship of the NHIA. People living with mental disorders are entitled to benefit from these poverty alleviation policies. Participants discussed the anticipated role and impact of these policies in promoting overall mental healthcare delivery.

10.4.1 LEAP

LEAP is a flagship program implemented by the Government of Ghana as a poverty reduction and social protection strategy to support the vulnerable and impoverished people in Ghana (Sackey & Remoaldo, 2019). Started in 2008, the LEAP program supports people with low socio-economic background through regular cash transfers to help them meet their basic needs (Aikins et al., 2017). The SWCD department, through the LEAP programme, is responsible for providing support for people with disabilities, including people living with mental illness (Local Governance Act 936, 2016). However, the support over the years has favoured people with physical rather than psychosocial disabilities (Ae-Ngibise, Doku, et al., 2015). Participants discussed the operational challenges faced by the SWCD Department in

responding to the needs of people living with mental illness. An RMHC stated that the lack of resources is a challenge, which prevents the SWCD Department from carrying out their duties effectively for people living with mental illness:

> *"The SWCD Department has a role to play under the MHA, helping people with mental conditions in financial and economic employment, among others. However, we cannot principally depend on this Department alone to help persons with mental illness because they also have resource challenges that are affecting their work."*
>
> (IDI_#04, RMHC)

Other roles of the SWCD Department include providing counselling services, vocational training and linking persons with mental illness to support programs:

> *"We link people living with mental illness to NGOs for financial and other assistance, we counsel people not to discriminate against those with mental illness, and we also help to reintegrate patients back to society. We sometimes provide vocational training for patients so that they can take care of themselves."*
>
> (IDI, Social Welfare and Community Development)

As acknowledged by other participants, support of people living with mental illness by the SWCD Department is inconsistent, due to the unavailability of resources. An RMHC remarked:

> *"Occasionally, the SWCD department supports clients with mental health problems, but this is not something they are doing all the time. The SWCD department also has challenges with funding. For instance, funding to provide accommodation for homeless mentally ill becomes a challenge."*
>
> (IDI_#10, RMHC)

A community psychiatric nurse suggested that the low rate of inclusion of people with mental illness into the LEAP program might be due to a lack of resources to support all people with disabilities:

> *"Patients' names are being forwarded to the SWCD Department for benefits, but most of them are denied. For instance, last year, out of the 361 applications submitted on behalf of people with mental disorders, only 5 were supported. The reason given for such a low success rate was that other people also needed to be supported."*
>
> (FGD_#03, Community Psychiatric Nurse)

Another community psychiatric nurse suggested that staff of the SWCD Department might lack understanding of the complex needs of people with psychosocial disabilities and how they

qualify for support under the program. This participant added that the SWCD Department should be cognisant of their role and responsibilities under the MHA:

> *"Personnel of the SWCD Department have difficulty understanding their role and responsibilities under the MHA. We went to the department and discussed issues with them, initially, they were reluctant to include people with mental disorders on the LEAP program because they did not even know where to classify people with mental illness. However, as time went on, they understood things a bit and started supporting people with mental disorders. So, I think that the SWCD department should be further educated to understand their role under the MHA."*
>
> (FGD_#04, Community Psychiatric Nurse)

Commenting on the lack of understanding of the role of the SWCD Department in supporting people living with mental disorders, an RMHC explained that whereas some districts have been supporting people living with mental illness, others have yet to start doing so:

> *"The SWCD department in some districts have been able to register some people with mental illness on the LEAP program; some districts are yet to do that. It needs much advocacy, stakeholder engagement, and dedication to understand that people with mental illness should be included in the LEAP program. In the past, people did not know that mental illness can be a disability. The awareness is gradually increasing so we should see further progress."*
>
> (IDI_#05, RMHC)

A clinical psychologist confirmed that the SWCD department has been registering people with mental illness, albeit there are many more who could benefit from this social intervention policy:

> *"Yes, some of the patients are registered with the SWCD department. We actively advocated for them to be registered with the LEAP Program through SWCD in Accra."*
>
> (IDI, Clinical Psychologist)

A carer of a mental health service user corroborated the claim that some people living with mental illness have been registered but have yet to start receiving the quarterly benefit in the form of cash transfer from central Government.

> *"Recently, staff from the SWCD department wrote our names to support us, but we have not received anything yet. The Government does not regard people with mental illness as a high priority; hence the slowness in getting us these benefits."*
>
> (FGD_#04, Carer of a Mental Health Service User)

Representatives of two NGOs and an RMHC in discussing the slow uptake of people with mental illness into the Government's social protection policies stated that it is due to a lack of resources to adequately educate relevant institutions to understand their role and responsibility

under the MHA. These participants commented that there was a need to educate social service providers to include people with mental illness in social intervention programs:

> *"Some people living with mental illness benefit from the social protection policies, but there is much more that needs to be done to cover all who need to benefit. It is only recently that people with mental illness are being enrolled onto the LEAP program provided through the SWCD for people with disabilities. Previously mental illness was not regarded as disabling sections of society. However, we have been able to educate some officials of the Social Welfare and the District Assemblies about the intent of the mental health reforms. Few Assemblies have understood and are supporting with the 3% DACF for persons with disabilities, but we are yet to address the issue with all the Assemblies due to limited resources."*
>
> (IDI_#03, NGO)

> *"Some social service providers do not understand that those living with mental illness can also benefit from disability funds. Nevertheless, places where you meet social service providers who understand the relationship between mental illness and disability have started registering people with mental illness as beneficiaries of these social intervention policies. So, we need to educate these social service providers to understand this role."*
>
> (IDI_#02, RMHC)

It is a responsibility of mental health workers to inform people living with mental illness about livelihood support programs such as LEAP and to assist them to understand the criteria for receiving remunerative support. However, there are insufficient resources such as means of transport to enable staff to travel to the communities to disseminate this information. Therefore, some patients and carers are unaware of the social intervention programs available to them:

> *"Some people with mental illness are not registered under the LEAP program because they lack awareness of its existence. So, it is the responsibility of the mental health personnel to inform them. However, there is no means of transport to the communities to inform people."*
>
> (IDI, Community Psychiatric Officer)

In contrast, a representative of an NGO discussed a commitment on the part of the SWCD and the NHIS to register people with mental illness:

> *"We have been advocating for free registration for people with mental illness as indigents on the social intervention policies such as the NHIS and LEAP. In some places, it is working, and in others, it is not. There is a 3% DACF for persons with disabilities in place but limited because people with psychosocial disabilities are usually not classified among those with disabilities because people think their disability is not broadly manifested in their physical appearance. However, we are still working on ensuring that people with mental illness are included."*
>
> (IDI_#02, NGO)

Resource limitation was cited by some research participants for the inability of key institutions to perform their roles satisfactorily. Some social protection agencies are under-resourced to provide the kind of services to people with mental illness as anticipated. Two RMHCs considered:

> *"With social services, I do not think we are doing too well as a country because the SWCD as we all know is severely under-resourced and unable to carry out that mandate to offer social services. People living with mental illness are supposed to be registered free of charges under the NHIS law. However, I know that the NHIS only pays for patients' physical health needs, not their mental health needs."*
>
> (IDI_#09, RMHC)

Lack of policy awareness of critical clinical staff was highlighted by a psychiatrist when she indicated that she was unaware of any support systems for people with mental illness seeking treatment from the teaching hospitals:

> *"I work in a teaching hospital, and so far, patients are unable to assess any of these facilities. Probably these facilities are available to those in the communities or more in deprived areas. But in the teaching hospital, I have not yet seen patient benefiting from some of these social protection programs."*
>
> (IDI_#01, Psychiatrist)

10.4.2 NHIS

As a key stakeholder, the NHIS was established as part of a poverty reduction strategy to make healthcare affordable to all Ghanaians. As a social protection policy introduced by the Government of Ghana in 2003 (National Health Insurance Act, 2003), the NHIS was established as a safety net to ensure that all Ghanaians have access to essential health services. While persons with mental disorders are supposed to register free of charge, the Scheme provides negligible coverage for accessing mental health services (Agyepong & Adjei, 2008). The policy directive underpinning the NHIS covers only the physical health needs of people living with mental illness. It can be argued that non-inclusion of mental healthcare under the NHIS is due to the fact that central Government provides or is mandated to provide free mental healthcare.

Nonetheless, psychotropic medicine, an essential component of mental healthcare, is unfortunately not consistently available for patients. Key stakeholders are lobbying central Government for the inclusion of mental healthcare under the NHIS to improve psychotropic medication supply. A community psychiatric nurse described how the non-inclusion of the mental health services on the NHIS was affecting mental healthcare delivery:

> *"NHIS registration of people with mental disorders is free of charge, just last year, we facilitated the registration of some patients onto the Scheme. The challenge is that the NHIS does not cover the cost of psychotropic medicine. Therefore, patients who have been registered under the NHIS still cannot access psychiatric treatment."*
>
> (FGD_#03, Community Psychiatric Nurse)

A senior representative of the Municipal Health Insurance Scheme argued against the inclusion of mental healthcare under the NHIS:

> *"The NHIS does not cover mental illness, but physical health conditions that may arise out of the mental illness are covered. We are currently registering people with mental illness free of any charges to take care of their physical health needs. Psychotropic medicines are program drugs and supposed to be provided free of charge by the Government; hence, they are not covered under the national health insurance policy."*
>
> (IDI, Municipal Health Insurance Authority)

This perplexed situation concerning mental health funding and the NHIS was further highlighted by a clinical psychologist and municipal director of health services who both confirmed that they have been assisting people living with mental disorders to register under the NHIS:

> *"Yes, some patients are also registered under the NHIS. Currently, when the annual subscription expires, I have to write a cover note for the renewal. So, we register patients in batches so that they can access the insurance for their physical ailments."*
>
> (IDI, Clinical Psychologist)

> *"I know people with mental disorders have been registered under the NHIS, although I cannot give you the exact numbers. We facilitated this registration last year for patients in the communities."*
>
> (IDI. Municipal Director of Health Services)

Further to this confused policy state, a policymaker with the NHIS reported that people with mental illness are registered as indigents under the NHIS where the individual does not have the personal resources to provide for their care. The insurance policy only covers their physical health needs:

> *"We register persons with mental illness free of charge as indigents under the NHIS. However, we take them off the scheme as soon as they are appropriately diagnosed as suffering a mental health condition. So, drugs for physical illness are covered under the NHIS but not psychosocial treatments. In terms of coverage, we do not search for cases to register; instead, we register all persons with mental illness brought to our offices."*
>
> (IDI, National Health Insurance Authority)

It is evident from an NGO representative response that further clarity is required around the critical interface between what is and what is not covered under the NHIS concerning mental illness:

> *"We have facilitated several hundreds of people with mental illness to register free of charge with the NHIS. It is not an automatic event though the law provides for it. So that is why we work with the self-help groups where they are organised, and they can be quickly mobilised and taken to the health insurance offices to be registered."*
>
> (IDI_#01, NGO)

The NHIS law exempts people with mental illness from paying to register for health insurance because they are classified as indigents and supposed to be registered free of charge. This registration exercise was ongoing in some regions with financial support from the United Kingdom's FCDO. An RMHC and a senior psychiatrist discussed the following which is a source of benefit to patients:

> *"For NHIS, the law exempts persons with mental disorders from paying for registration. Last year, we started a program with the support from FCDO to register a lot more people with mental disorders on the NHIS. So, for the Greater Accra Region, we have facilitated the registration of about three hundred people with mental illness onto the NHIS."*
>
> (IDI_#05, RMHC)

> *"To the best of my knowledge yes, once you are identified as a person with a mental illness, the NHIS is supposed to register you free of any fees. In my institution, we have used that provision in the NHIS law to provide free physical health services to some of our patients."*
>
> (IDI_#02, Psychiatrist)

An RMHC indicated that lack of funding was a significant factor obstructing nationwide registration of people with mental disorders with the NHIS:

> *"The NHIS has been registering people with mental disorders as indigents in some districts, I do not know precisely why that is so, but I know that the NHIS is facing financial challenges; hence, they cannot register all people living with mental disorders."*
>
> (IDI_#10, RMHC)

> *"The directors of the Municipal SWCD and the NHIS have demonstrated interest in registering people living with mental illness in the Kintampo area despite insufficient resources at their disposal."*
>
> (IDI, Community Mental Health Officer)

The excerpt from an RMHC highlights the difficulty where policies formulated at national level often face the challenge of ensuring some degree of consistency in delivery at subnational

level, a process that is especially fraught where the subnational level has some separate degree of political authority as is the case in Ghana:

> *"We are in the process of registering people with mental illness onto the NHIS. Last year, we were given funds from the GMHA through FCDO to register these people under the scheme. We are also currently compiling these names which will be channelled through the district and regional Social Welfare offices for approval before they are included in the LEAP program."*
>
> (IDI_#06, RMHC)

A further RMHC identified that poor governance and eligibility guidelines had led to confusion and system rorting. The current process slows the rate of registration of persons living with mental illness on the NHIS. This participant argued for greater policy governance to prevent further rorting:

> *"We register people identified as living with mental illness free of charges on the NHIS because they are classified as indigents. However, my checks with the regional human resource manager of the NHIS revealed that they have put in a lot of stricter guidelines to prevent some people who are not eligible to access this facility because some people have already started abusing the system. So, we now have to compile the list of people with mental illness and pass them through the SWCD to NHIS headquarters in Accra before approval is granted to register patients."*
>
> (IDI_#03, RMHC)

However, a mental health service user disclosed that he was not a beneficiary of the social intervention programs even though he has made some attempt to get registered but never succeeded:

> *"Never at all, just last year, after disclosing my mental health status to them, I still paid twenty-seven Ghana Cedis for Health Insurance registration. I am not benefiting from the LEAP program after registering with them a long time ago."*
>
> (IDI, Mental Health Service User)

10.5 Legal and security services

The legal institutions, which include Judicial, Police and the CHRAJ, are critical stakeholders in mental health and are expected to play vital roles to ensure the implementation of the MHA. A community psychiatric nurse argued that the Judiciary has a moral obligation to ensure that central Government commit resources for the implementation of the MHA:

> *"The Judiciary should demand from the central Government to be committed to the implementation of the MHA. The Law Reform Commission (LRC) first reviewed the mental health bill before parliamentary approval and subsequent executive assent. Therefore, the Judiciary has a moral duty of using its legal means to ensure Government commit resources for implementing the MHA."*

(FGD_#03, Community Psychiatric Nurse)

It is of paramount importance that the judiciary understand the critical relationship between the concept of therapeutic jurisprudence and mental health law when dealing with an offender who's offending has been consider by a senior mental health clinician to be secondary to their mental state. A senior mental health administrator in acknowledging the pivotal role that the Judiciary have to play to promote mental health reform asserted that a lack of resourcing had resulted in only 67% of judges receiving education on operational aspects of the MHA:

> *"The Judiciary has a role to play in respect of the MHA implementation. In the last two years, we trained more than half of the 400 members of the Judiciary to understand mental health and the need to protect patients' rights. The training was done for judges to appreciate the need to refer accused persons suspected of having a mental illness to the health facilities for mental health review before committing them to trial. We have to train all the remaining 200 judges, but lack of funds prevents us from accomplishing this training."*

(IDI, Senior Mental Health Administrator)

A magistrate acknowledged their responsibility under the MHA to refer offenders for a psychiatric assessment where their behaviour had been considered to be influenced by mental illness or other severe neurocognitive disorder at the time of offending:

> *"We are also stakeholders and our role as the law protector is to refer accused persons suspected to be mentally unsound for psychiatry assessment before trial."*

(IDI, District Magistrate)

Attempted suicide in Ghana is currently illegal as it is classified as a misdemeanour under Act 29 of the criminal code (Ghana Criminal Code, 1960); therefore a suicide attempt contravenes this provision and is punishable under law (Adinkrah, 2013; Akotia et al., 2020; Quarshie et al., 2019). The GMHA is advocating for decriminalisation of suicide in Ghana. Participants in this research argued for change in this area and that the Judiciary should ensure that it assesses suicide as a behaviour that has been influenced by mental illness or some significant event in the individual's life that interferes with their personal functioning. An RMHC stated:

> *"We have sensitised the Judiciary, and we are hoping that something like suicide attempt should be seen as a mental health issue and needing a psychiatry assessment instead of criminalising it or putting people in police cells because of suicide attempts. So, the Judiciary should take this role very seriously so that people with mental illness are not put behind bars as criminals."*

(IDI_#02, RMHC)

The CHRAJ is a state institution responsible for protecting and enforcement of human rights of every citizen in Ghana. A representative of CHRAJ confirmed:

> *"CHRAJ must ensure that we protect and enforce the rights of every citizen, including those living with mental illness in Ghana. As the name of the commission portrays, Commission for Human Rights and Administrative Justice, and this was enacted in Parliament in 1993, Act 456 basically to protect Ghanaians' rights."*
>
> (IDI, Municipal Director, CHRAJ)

An RMHC and a senior mental health administrator also considered that CHRAJ has a significant role to play to ensure the implementation of the MHA. These participants, however, bemoaned the lack of resources arguing that insufficient funding has prevented CHRAJ from executing this role effectively:

> *"Yes, CHRAJ has a crucial role to play in support of the mental health reforms. You know, violation of human rights is still staring us in the face, especially against people living with mental ill-health. When people's rights are violated, sometimes they do not know where to report these issues for redress. CHRAJ is supposed to interpret violations of people rights as stated in the law and prosecute all alleged human rights violations to serve as a deterrent to others."*
>
> (IDI_#07, RMHC)

> *"The CHRAJ has a significant role to play to ensure the patient's rights are protected. CHRAJ is supposed to visit all mental health facilities to ensure that health facilities are complying with human rights protocols, but they are not performing this task well due to limited resources."*
>
> (IDI, Senior Mental Health Administrator)

The Ghana Police Service is the main law enforcement agency in Ghana. The concept of therapeutic jurisprudence extends to the police requiring them to refer offenders suspected of being mentally unwell, or who suffer from a major neurocognitive disorder for psychiatric assessment. A psychiatrist stated:

> *"Under the MHA, the Police Service is mandated to identify persons at risk in the communities, particularly those at risk to themselves and others, including people living with mental disorders by assisting them in seeking healthcare."*
>
> (IDI_#02, Psychiatrist)

A Divisional Police Commander confirmed that the police are responsible for upholding the fundamental rights of all people within the legal and justice system:

"As stakeholders, when we affect an arrest of suspected criminals, depending on the person's posture and behaviour in question, we can ask and refer the person for a psychiatric assessment to ensure that the person is fit for trial at the law court."

(IDI, Divisional Police Commander)

However, a senior mental health administrator indicated a need to train the police to be able to perform their role of protecting the rights of people with mental illness as provided for in the MHA:

"We need to train the Police because they might be the first people to come in contact with persons with mental illness who have committed a crime. So, we need to train them to recognise signs of mental illness and refer suspected cases of people with mental illness to us for psychiatric assessment before prosecution. So, the Police Service has a major role to play in the new mental health reforms."

(IDI, Senior Mental Health Coordinator)

The NCCE is a Government agency responsible for the education of all Ghanaians on civic matters. The Commission was established in 1993 under Act 425 of the Parliament of Ghana. A representative of the NCCE acknowledged the Commission's advocacy responsibility, but as with previous (see section 9.5) Government departmental administrators, the participant lamented a lack of resourcing as the main impediment to NCCE educating the public about Government policies and programmes:

"Yes, the NCCE has an important advocacy role of educating the public about mental health and mental illness. NCCE as an advocacy organisation, our mandate is to educate the public to accept people with mental illness in our society and treat them well, but we are constraint by limited logistics to perform."

(IDI, NCCE)

10.6 NGOs

NGOs play a major mental health advocacy as well as care delivery role in Ghana. A clinical psychologist stated that NGOs provide supplementary funding for mental health service delivery:

"NGOs have a crucial role to play in facilitating the implementation of the MHA. For funding, it would never be adequate, and so NGOs provide logistics, training, and motorbikes, which helps reach out to the remote areas. Some of the NGO's are playing an advocacy role, and I know BasicNeeds Ghana is doing well in these areas and was very instrumental in even drafting some portion of the LI."

(IDI, Clinical Psychologist)

An RMHC asserted that mental health focused NGOs in their region were well established and providing services in advance of Government services provided through GHS and the GMHA:

> *"NGOs are very supportive and have contributed to the improvement and recognition of health in the region. I can even say it was the NGOs that started mental health activities in the region before the GHS and the GMHA. The NGOs are major mental health advocates in the regions."*
>
> (IDI_#03, RMHC)

Two members of Parliament acknowledged the important role played by NGOs in advocating and in some cases funding mental healthcare:

> *"NGOs play an advocacy role and sometimes support with funds to execute mental health programs. NGOs also go a step further in advocating for support from benevolent organisations to support their daily operations of the GMHA. NGOs also advocate for protecting patients' rights, which will making the Government focus more on mental health issues."*
>
> (IDI_#01, Member of Parliament, Ghana)

> *"NGOs play an important role in mental healthcare, particularly the delivery of help to vulnerable groups. NGOs are the voices of the voiceless; without them, we cannot make progress as far as mental health is concerned. Thus, it is critical for these organisations, including the churches, opinion leaders and chiefs and queen mothers to always talk for people living with mental illness to improve mental health service delivery."*
>
> (IDI_#02, Member of Parliament, Ghana)

In Ghana generally, NGOs are well organised, better resourced, and advocate strongly for better mental health services for people living with mental illness. One of the NGOs was described as providing better support for mental health activities compared with the state. A community mental health officer indicated:

> *"The NGOs are generally well established, they have the financial muscle, and because they are organised, they should continue advocating for better services for people living with mental illness. I know an NGO which I can even say is doing better as a stakeholder in promoting mental healthcare than the state."*
>
> (IDI, Community Mental Health Officer)

NGOs in general have greater organisational agility and are less constrained by cumbersome bureaucracy. In further highlighting the significant role of NGOs, an RMHC and a Municipal Local Government Inspector disclosed that some of the NGOs started sensitising the general public about the existence of the MHA before monies were released from central Government for that purpose:

> *"NGOs have played a major role, some NGOs had even started sensitising the general public on the MHA before the GMHA provided some funds to carry out education. NGOs such as*

BasicNeeds Ghana took the lead role in improving the general public's knowledge on the MHA before we were given funds to start educating. BasicNeeds Ghana contributed significantly to creating awareness of the existence of the MHA."

(IDI_#06, RMHC)

"NGOs play an advocacy role in informing people about mental health and the consequences of allowing people who have mental illness roaming the streets and the need to stop human rights abuse in the traditional and faith-based healing centres."

(IDI, Municipal Local Government Inspector)

Apart from advocacy, which was considered a key role, NGOs provide logistics to facilitate community outreach programs for mental health services. A senior mental health service administrator and a senior psychiatrist explained:

"The role of NGOs is mostly advocacy, and they have been playing that role very well. So, they are advocating and helping in solving our issues a little bit. Without them, we would have been less affective, and no matter what you say, no one will listen to you, so they play a major advocacy role. NGOs also facilitate the spread of mental health services in the regions. BasicNeeds Ghana, in particular, provides logistical support which facilitates outreach programs by which psychiatrists can offer services to patients."

(IDI, Senior Mental Health Administrator)

"NGOs have been supporting community outreach programs; one prominent NGO is BasicNeeds Ghana, that supports doctors or specialists to go to remote areas to render specialist psychiatric clinic for people who live in areas where they would not have received mental healthcare. Thus, NGOs are incredibly supportive, and we need a lot more NGOs like BasicNeeds Ghana to help improve mental healthcare."

(IDI_#01, Psychiatrist)

Two participants further expanded on the role of NGOs in supporting mental health service delivery explaining that they provided technical support to Government in developing the mental health reform agenda and LI, and have continued to lobby Government for full implementation of the MHA:

"Our role is to advocate for better health services for people with mental health conditions. We were part of the technical team that developed the MHA. We are advocating and raising awareness of mental health issues and pushing the Government to implement this MHA fully. Together with other stakeholders such as the WHO, mental health workers, we drafted the MHA and began advocating for State funding, until it was passed into law in 2012. We are deeply involved in advocating for the passage of the LI."

(IDI_#02, Non-government Organisation)

"These NGOs advocated for the passage of the MHA, they are currently pushing to ensure Parliament passes the LI. They have facilitated meetings with the health committee of Parliament to discuss the way forward for LI's passage. So, NGOs such as Mind Freedom,

> *BasicNeeds Ghana and Psychosocial Africa advocate and educate the public on mental health issues."*
>
> (IDI_#05, RMHC)

A senior representative of another mental health-related NGO explained the role of the organisation towards mental healthcare as well as the implementation of the MHA:

> *"By our vision and mission, we have a responsibility to support the basic needs and fundamental rights of people experiencing mental ill health, epilepsy and their primary carers. We think we have an obligation to ensure that the MHA is implemented to the letter for the benefits of persons with mental illness."*
>
> (IDI_#01, NGO)

Another RMHC singled out BasicNeeds Ghana as a respected lead NGO in performing critical roles such as livelihood support programs and empowerment for people living with mental illness. Some of the NGOs also facilitate the supply of psychotropic medications:

> *"I know NGOs in mental health are doing an outstanding job; I can mention BasicNeeds Ghana, which is very popular, Mind Freedom and others. BasicNeeds, Ghana is helping with livelihood programs and other aspects of life. These NGOs help empower people with mental illness so that they can function meaningfully in society after recovery. They also help with medication procurement, which is a massive challenge because of the frequent shortage of medication for patients."*
>
> (IDI_#04, RMHC)

An RMHC discussed three mental health-related NGOs in his region that were performing roles such as advocacy, educating people about mental health and mental illness, drugs and alcohol use, and also in providing rehabilitation of people with mental illness:

> *"NGOs are engaged in advocacy, educating the public about mental health. There are three NGOs interested in mental health in my region; BasicNeeds Ghana, Passion for Total Care and Life Out of Alcohol and Drugs. BasicNeeds Ghana primarily focuses on livelihood empowerment, Passion for Total Care provides rehabilitation and Life Out of Alcohol and Drugs focuses on alcohol and drugs issues."*
>
> (IDI_#08, RMHC)

The core mandate of the Ghana Federation of Disability Organisations (GFD) is to advocate for the rights of people with disabilities. GFD has been engaged in policy reform advocacy for all its member, including those with mental illness. A representative of this NGO remarked:

> *"As a secretariat, the GFD coordinates all disability groups, including those with mental or psychosocial disabilities, and ensures equal participation of the disability organisations. The GFD mostly handles policy-level engagements, advocacy for reforms, better services and access for people with disabilities in public places."*
>
> (IDI_#03, Non-government Organisation)

Notwithstanding the significant advocacy role performed by NGOs towards mental health service provision, there can be difficulty accessing the services of NGOs in some regional areas:

> *"I think NGOs play a major role in advocacy, but unfortunately, in my region, we seem not to have any NGO that operates within that catchment area focusing on mental health."*
>
> (IDI_#10, RMHC)

Further to the core advocacy role described by participants, some NGOs have been involved in capacity building and empowerment of both mental health professionals and people living with mental illness. Other NGOs supplement Government through structural services such as renovating offices for Government mental health staff. An RMHC discussed these in the following quote:

> *"Some NGOs have been supporting capacity building of mental health staff through workshops and furnishing offices. Some of the offices were furnished by BasicNeeds Ghana and the Centre for Development of People (CEDEP), but these NGOs currently have insufficient funding to continue their work."*
>
> (IDI_#01, RMHC)

10.7 Community opinion leaders

Community opinion leaders are individuals whose opinion in specific issues is respected and held in high esteem by the community members (Asante et al., 2013). Ghana is one amongst many African countries where traditional authorities persist within newer modes of governance. Traditional chieftaincy exists alongside the democratic and political structure of the country. The concept of traditional Chiefs and Queen Mothers are selected in accordance with custom and elected to provide authority and functions derived from tradition practice at a local level. Community durbars (court of a native ruler) are commonly used by traditional leaders to educate their community about important local and national issues. A durbar serves as a platform for traditional chiefs, community leaders and representatives from District Health Directorates to discuss important health issues such as rights and responsibilities under the MHA. A clinical psychologist considered:

> *"Community opinion leaders play a crucial role in linking people with mental illness to health facilities. These leaders can help the health staff identify patients in their communities, especially those hidden by their relatives due to stigma. So, they relay some information that is vital to health workers and community members."*

(IDI, Clinical Psychologist)

The traditional Ghanaian family structure, which extends to the entire community has a social responsibility of supporting people living with mental illness. A psychiatrist remarked:

> *"You cannot take away the importance of social support from the family, friends, colleagues, and church members, so in effect from the community at large in addressing mental health issues. The communities are governed by community opinion leaders who are key stakeholders in advocating and protecting the rights and dignity of persons living with mental illness."*

(IDI_#02, Psychiatrist)

Similarly, a representative of the Municipal Health Insurance Scheme stated that community opinion leaders have the responsibility of rallying key stakeholders to support people living with mental illness:

> *"As traditional landowners, community opinion leaders have to bring together all stakeholders such as Social Welfare, health service providers and family carers of people living with mental illness to support patients. Moreover, community opinion leaders should be leading education about the need for people living with mental illness to seek early treatment at the health facilities."*

(IDI, Municipal Health Insurance Scheme)

Participants discussed further that community opinion leaders are the community representatives and are expected to perform a vital role in advocating for improved mental health services for people living with mental illness. An RMHC believed the involvement of community opinion leaders in mental health advocacy could help to reduce stigma and discrimination against people living with mental illness:

> *"Some of the community opinion leaders are elected, and as the advocate of the people, they represent the people, and people have high trust in them. So, persons like the Chiefs, Queen Mothers and others, when they talk, people listen to them. Since our focus now is on community-based mental healthcare, opinion leaders can help to reduce stigma and discrimination by speaking openly against it and advocating for patients' rights."*

(IDI_#04, RMHC)

Another RMHC reiterated that it is an expectation of a community opinion leader to ensure the rights of people with mental disorders are protected and not abused, stigmatised or

discriminated against. They are also required to support people with mental ill-health to get treatment through various advocacy programs:

> *"As community representatives, community opinion leaders have to ensure that people with mental illness are not discriminated or stigmatised against through advocating on their behalf. These leaders have to speak against stigma and discrimination and ensure that these negative vices do not happen in their communities. You know these leaders carry much power, and whatever they say is what their followers do. Furthermore, they should also ensure that persons with mental illness in their communities get medical treatment."*
>
> (IDI_#05, RMHC)

Community opinion leaders are expected to play care roles to compliment immediate family members of people living with mental illness. An RMHC stated:

> *"For community opinion leaders, when we engage them during the community durbars, we ask that the care of the patient is not left solely to the family, as a community, they should come on board to support through advocating for better services for them."*
>
> (IDI_#02, RMHC)

A municipal local Government inspector explained further that community opinion leaders have a duty of informing community members about mental health and the potential risks associated with not providing shelter for people with mental illness:

> *"Community opinion leaders should play an advocacy role; they should come together and educate their people about the dangers of not providing shelter for people with mental illness roaming the streets and the need for patients to seek treatment from the health facilities."*
>
> (IDI, Municipal Local Government Inspector)

A representative of an NGO discussed at length the influence that traditional leaders have within their communities:

> *"We need to work closely with the traditional authorities because they are very influential people in our communities, and their advice or behaviour influences others. If traditional authorities are more accommodating of persons with mental disorders, families and community members will have different attitudes towards persons with mental disorders. Imagine the Asantehene (Chief of the Asante Kingdom) makes a statement that persons with mental disorders should not be abused and that people who have relatives who have mental illness and roaming the streets should be taken back home, I believe you will see a reduction in the number of persons with mental disorders who are destitute and roaming the streets in Kumasi. So, yes, traditional authorities are quite an influential group, and their actions or inactions can protect or expose persons with mental disorders to more abuse."*
>
> (IDI_#01, NGO)

A traditional leader also considered that community opinion leaders need to be involved and educated to play an advocacy role in promoting mental health policy uptake. According to the participant, community members obey the instructions of community leaders, and therefore, it will be easier for these leaders to promote mental health activities:

> *"We have command over the people, making things easy for the Ministry of Health to involve us in policy implementation because our people listen to us, they understand us, whatever we tell them they do that. So, we have a vital role to play. We need to educate all other opinion leaders to understand the importance of mental health, that mental illness does not discriminate on class or position not even the chief or the assembly members are immune. I think when these leaders are enlightened, they will help promote mental health in their communities."*

(IDI, Traditional Ruler)

An RMHC explained the importance that has been applied within his region to engage and train traditional leaders. It is anticipated that the knowledge gained will be shared with their respective communities through regular community durbars:

> *"The role of community leaders is crucial, and we have engaged most of these leaders with funding from some NGOs. We were able to bring in local chiefs (Danaas), community youth leaders (Zaachis) and female leaders (Magazias) together and educated them about the MHA. This was to empower these leaders with the knowledge to have an impact within their communities."*

(IDI_#06, RMHC)

Another RMHC discussed the importance that his region had placed on educating community leaders including traditional leaders:

> *"The community opinion leaders, the Chiefs, Queen Mothers live in the same communities with people who have a mental illness. They have the responsibility to ensure that anybody who develops a mental illness within their jurisdiction seeks treatment from the mental health facility. So, that is why we keep educating these community leaders."*

(IDI_#03, RMHC)

A human rights activist stated that although community opinion leaders have a role to play, some also believed in traditional and faith-based healing because of the perceived relationship between spirituality and mental illness. A commissioner of CHRAJ suggested:

> *"Community opinion leaders are essential in promoting mental health, but a study has revealed that some of these opinion leaders also believed in local treatment by TFHs for mental disorders. Some of these leaders believed that mental illness is spiritual and should be treated by TFHs. So, instead of helping patients to seek treatment at psychiatric units of the various health facilities, they prefer the local and spiritual treatments."*

(IDI, Municipal Director, CHRAJ)

However, an RMHC described some community opinion leaders as not supportive of mental health activities, hence the lack of patronage and participation in community programs aimed at supporting people living with mental illness. An RMHC observed:

> *"Community opinion leaders are supposed to protect people's rights with mental illness, but some of them are not interested in mental health. This had been observed in some programs such as community durbars that we sometimes organise to discuss mental health issues, where you will always meet only service users and their carers but not the community leaders. We need more education for these leaders to play their advocacy role well."*

(IDI_#01, RMHC)

A senior mental health administrator and district magistrate also pointed out that that community opinion leaders need to be informed to be able to perform their roles effectively as mental health advocates in their respective communities:

> *"So far, our community opinion leaders have not done much in terms of mental health advocacy. We need to educate and use their influence to promote the MHA and mental healthcare in their communities. Out of their own will, these leaders may not do that, so we always need to go to the communities and get them on board to help us achieve our aims."*

(IDI, Senior Mental Health Administrator)

> *"The Chiefs and Queen mothers are paramount and influential people in the community; they need to get on board and play an advocacy role for people living with mental disorders."*

(IDI, District Magistrate)

The participants felt that community opinion leaders have a role to play in mental health service provision. Nevertheless, these leaders need to develop capacity to be able to provide strategic advocacy and campaigns to ensure mental health services are available for people living with mental illness. The implication is for GMHA to continue to engage and include community opinion leaders in annual programs to improve their advocacy and communication skills as community agents.

10.8 Mental health service providers

The GMHA, as a regulatory body, has the primary responsibility of ensuring that mental health service is delivered effectively by facilitating the implementation of the MHA:

> *"The GMHA is directly responsible for ensuring that the MHA is implemented to promote overall mental healthcare across the country. Although the GMHA is doing the right thing, inadequate resources are preventing the implementation of the MHA."*

(IDI_#07, RMHC)

The research participants discussed that RMHCs have a core duty of coordinating all mental health activities in the various regions, including facilitating the implementation of all mental health policies under the supervision of the GMHA. The RMHCs are also responsible for ensuring equitable distribution of mental health workers across the various districts in the regions, especially those health facilities that do not currently provide mental health services. An RMHC stated:

> *"The core duties of the RMHCs are to coordinate mental healthcare and ensuring the implementation of mental health policies in the various regions. We are supposed to coordinate all mental health activities by Government and private institutions."*

(IDI_#04, RMHC)

In performing the duties as RMHCs, the enabling environment including the allocation of necessary resources (funding and personnel) is imperative for these coordinators to achieve progress. Although the RMHCs are responsible for ensuring equitable distribution of mental health workers in their various jurisdiction, there remains a shortage of skilled mental health professionals. In addition, funding will have to be allocated from Central Government through the GMHA to the RMHCs for supervision of mental health activities. The use of the RMHCs will be a key strategy to achieve the needed service change across the country.

A senior mental health administrator acknowledged the intrinsic role of service providers in facilitating the implementation of the MHA through the integration of mental health services into primary healthcare. He, however, admitted the lack of penetration of the MHA and the need to train general health professionals to support the mental health reforms in Ghana:

> *"Mental health service providers have a duty of integrating mental health services into general healthcare, especially as we aim for universal health coverage for all. We need to train nurses, clinicians and other health practitioners in the communities so that they will gain some understanding of the MHA to be able to provide basic mental healthcare in all health facilities. We have been training health workers on the Mental Health Gap Action Program [mhGAP], now Quality Rights programs for this integration purpose."*

(IDI, Senior Mental Health Administrator)

A clinical psychologist also described his role, which included the provision of therapeutic services and liaising with social protection agencies to provide social support intervention for people living with mental illness:

> *"As a clinical psychologist, I provide clinical services to patients. I provide basic counselling or therapeutic services for students and a wide range of other clients. I also provide some psychosocial interventions, liaising with other service providers such as SWCD, CHRAJ, and others to support people living with mental illness."*
>
> (IDI, Clinical Psychologist)

Community psychiatric nurses who participated in the study indicated that they are responsible for ensuring that the MHA is implemented. Some of these roles include identifying people living with mental illness, provision of mental health services, and facilitating home visits to patients to check on treatment progress. However, insufficient resources and logistics were identified as the main barrier preventing them from effectively executing these responsibilities:

> *"It is our duty to identify mental health patients at the sub-district level. We embark on case identification and referral to the CPO at the municipal hospital for diagnosis and further treatment. We also organise school health activities to screen students and refer potential clients accordingly. We do home visits to also check on medication adherence and family support systems for patients."*
>
> (FGD_#01, Community Psychiatric Nurse)

A medical superintendent of a municipal hospital stated that his office is responsible for ensuring that mental health services are provided within the municipal hospital, indicating that a unit had been established and currently providing services for people with mental illness:

> *"There is a mental health unit at the municipal hospital, which mainly takes care of people with psychiatric conditions. My role is to make sure that the unit is appropriately accommodated within the general hospital. The mental health Unit generates its own data, and facilitates the collection of psychotropic medication from the regional medical stores for patients."*
>
> (IDI, Medical Superintendent)

Other responsibilities of mental health service providers include provision of basic mental health awareness to the general publics, especially key stakeholders about the MHA. An RMHC and a senior psychiatrist emphasised:

> *"We have a role in ensuring that all people are educated about the MHA. Key stakeholders such as the Judicial Service, the Police Service, Ghana Education Service, the SWCD, the TFHs; and more importantly, we have a duty to provide information to the general public to assist them to understand their rights and responsibilities under the MHA."*
>
> (IDI_#03, RMHC)

> *"As a psychiatrist, I have a role in ensuring that the MHA is operationalised by making sure that persons with mental illness get proper treatment and education and ensure the protection of patients and staff rights."*

(IDI_#02, Psychiatrist)

Despite acknowledging the important role of mental health service providers towards implementation of the MHA, the issue of inadequate resources such as psychotropic medication keeps presenting as a major inhibiting factor:

> *"Yes, we have a responsibility towards facilitating the implementation of the MHA, but many challenges are hindering the implementation of the MHA. For instance, medication is supposed to be free under the MHA, but these medicines are unavailable, and so patients have to buy them, which is against the spirit of the MHA. Most of our patients are from the low socio-economic backgrounds, and the insurance policy does not cover their medication."*
>
> (IDI_#01, RMHC)

A community mental health officer added to the growing voice of health professionals identifying inadequate resourcing as the main barrier to performance:

> *"We have the responsibility for ensuring that the general public is educated about the MHA but as a practitioner, I have not been fully informed about the MHA."*
>
> (IDI, Community Mental Health Officer)

10.9 Mental health service users and carers

As the principal beneficiaries of mental health services, mental health service users and carers are expected to play a key role in implementing the MHA. The study participants described this role as mainly advocacy for improved mental health service delivery. RMHCs discussed some of these essential roles:

> *"Family carers of people living with mental illness have a significant role to play. They have a caring and supportive role, supervisory role, being the advocate for their relatives, ensuring that their relatives are well taken care of, and protected from stigma and discrimination."*
>
> (IDI_#04, RMHC)

Mental health service users and carers have the core duty to advocate and lobby other relevant stakeholders to support the implementation of the MHA for improved mental healthcare delivery. An RMHC noted:

> *"Mental health service users and carers still have to advocate for better mental health service themselves, and also in advocating, they have to use the mental health law because they are currently paying for services that are supposed to be free by law. Service users need to know their rights so that they can lobby for better mental health services."*
>
> (IDI_#02, RMHC)

Similarly, other RMHCs acknowledged the advocacy role that mental health service users and carers are expected to perform. It was further suggested that mental health service users were expected to serve as peer educators to improve mental health literacy and improve treatment outcomes:

> *"I think their fundamental role is to advocate for improved mental health services. That is why we encourage them to form self-help groups to meet and provide feedback to service providers. Sharing lived experiences with others is a useful intervention strategy for the prevention and management of mental disorders. Service users can serve as peer educators in promoting mental health literacy in the prevention and treatment of mental disorders."*
>
> (IDI_#05, RMHC)

> *"Mental health service users and carers need to be encouraged to participate in provider education sessions. It is important that when users and carers come to the health facility that health providers include education about their rights and responsibilities under the MHA."*
>
> (IDI_#06, RMHC)

Mental health service users and carers have a role to play to promote the implementation of the MHA. However, a lack of understanding of the MHA was described as a barrier to the performance of this role:

> *"The role of service users and carers in advocating for better service provision is crucial for the implementation of the MHA. As key stakeholders, a number of users and carers' were involved in the initial drafting of the MHA. Their understanding is paramount for successful implementation of the MHA."*
>
> (IDI_#07, RMHC)

The capacity of mental health service users must be developed to ensure that they play their role effectively as advocates. Capacity development could include mental health literacy, knowledge of the MHA, and improvement in advocacy skills. A CPO considered that for mental health service users to understand their role and responsibility, further training should be provided:

> *"Service users have an advocacy role to play, but most of them do not know what the MHA is about. We need to organise awareness workshops explaining the MHA."*
>
> (IDI, CPO)

A senior mental health administrator reiterated the need for service users and carers to be educated and empowered to be able to advocate for their rights:

> *"Mental health users and their carers have an advocacy role to play in order to facilitate the implementation of the MHA. They have to be educated to stand for their rights when service providers, including TFHs, have abused these rights."*
>
> (IDI, Senior Mental Health Administrator)

On a similar topic, a representative of a municipal health insurance scheme and a clinical psychologist agreed that family carers of people living with mental illness have the duty of showing care towards service users. These participants described these roles as pivotal in promoting mental health service delivery:

> *"The family carers of service users have a significant role to play. They should not neglect them; they should get closer to them, take their medical needs seriously. The family carer needs to provide some love and comfort for patients to aid their healing."*
>
> (IDI, Municipal Health Insurance Authority)

> *"The carer can play an important role where necessary including supporting the individual with their medication management. If they are not adequately educated about the MHA, it is unlikely that they will access the treatment services that we provide."*
>
> (IDI, Clinical Psychologist)

10.10 Chapter Summary

This chapter has reported findings on the role of key stakeholders in facilitating the implementation of the new mental health reforms brought about by introducing the MHA. The research participants identified some of these key stakeholders which included the District Assemblies, SWCD, NHIS, legal and security services, NGOs, community opinion leaders, mental health service providers, mental health service users, and their carers.

As the central Government's local representative, participants identified the District Assemblies as key stakeholders responsible for ensuring that people with mental illness are adequately accommodated, treated, and supported to reintegrate into their community. The participants suggested that the District Assembly could use part of its common fund to construct shelters for people living with mental illness who are vagrants.

Under the supervision of the SWCD, the LEAP program provides financial support quarterly for people living with disabilities. Although the LEAP program initially did not cover people with mental or psychosocial disabilities due to a lack of understanding of the disabling effect of mental illness, the program is gradually enrolling people with enduring mental health disorders. Participants discussed the responsibility of the SWCD to ensure that people living with mental

disorders are not discriminated against and supported with the same resourcing as for people with physical disabilities.

It was noted that although the NHIS registers people with mental illness free of charge, the scheme offers limited coverage for mental health services. For instance, psychotropic medications are not covered under the scheme because these medicines are required to be provided free of charge by the central Government. However, due to Government under-funding of mental healthcare, some participants advocated for re-alignment and inclusion of mental healthcare, especially psychotropic medicines on NHIS.

Participants discussed that NGOs and community opinion leaders were performing an advocacy role and supporting supplementary funding for the uptake of mental health activities across the country. Some of the NGOs, such as BasicNeeds, were providing livelihood support programs and empowering people with mental illness to be able to demand better health services from health authorities. NGOs were considered instrumental in providing community mental health outreach programs.

The mental health service provider's primary role is to administer mental health service to people with mental disorders. It was felt that mental health service providers have a duty in facilitating the implementation of the MHA through the integration of mental health services into primary healthcare. The participants also reported that mental health service providers as a key stakeholder group were responsible for educating people with mental illness about their conditions and creating awareness about their rights and responsibilities under the MHA. Participants again pointed out that the lack of resourcing was impeding the performance of these responsibilities.

The legal and security services such as the judiciary, CHRAJ and the police service were identified as having responsibility for the protection of the human rights of persons with mental illness. The police service and law courts, for instance under the concept of therapeutic jurisprudence are required to refer accused people who exhibit symptoms of mental illness for a psychiatric assessment before committing them to stand trial. Personnel of these services have to be further educated better understand the provisions in the MHA for the protection of the rights of people living with mental illness.

The research participants further discussed the advocacy role of mental health service users in demanding their rights under the MHA. Participants considered that the formation of self-help groups for mental health advocacy was paramount if mental health service users and carers were to play this role effectively.

The participants discussed that inadequate funding and lack of political commitment were the most frequently identified barriers preventing the key stakeholders from performing the

statutory roles as anticipated. Participants suggested a need for more commitment from the central Government towards providing the required resource for the implementation of the MHA.

Chapter 11 discusses the findings of the study, focusing on the contribution to knowledge and practice, and provides strategic recommendations for ensuring the implementation of the MHA.

Chapter 11 Discussion and conclusion

11.1 Chapter Overview

This Thesis provides an in-depth assessment of the extent to which the statutory requirements of the MHA have been implemented in Ghana since its introduction in 2012. The study documents the barriers and enablers, examines the roles of TFHs involved in mental healthcare and provides strategic recommendations to enhance further implementation. This Thesis also addresses the role and importance of collaborating with TFHs to provide mental health services devoid of human rights violations that have previously characterised traditional and faith-based healing camps.

The discussion in this chapter is based on the study's broader research questions, drawing from the WHO HSBB and LHPS models. Strengths and weaknesses, and the general conclusion from the entire Thesis are presented. The contribution of this Thesis to knowledge and practice, to policy and priorities for future research are presented.

11.2 The research questions and major findings

The Thesis sought to answer four overarching research questions:

1. What is the degree of disability among people with severe mental disorders in the Kintampo North Municipality of Ghana?
2. What is the role of TFHs in implementing the MHA in Ghana?
3. What is the role of key stakeholders/institutions in implementing the MHA in Ghana?
4. What is the progress, barriers, and enablers for implementing the MHA in Ghana?

This chapter will address each of these research questions and a number of sub-questions in greater detail. Major findings from this Thesis have been grouped and discussed under four topic areas: degree of disability among people with severe mental illness; barriers and enablers to implementation of the MHA; role of key stakeholders/institutions in implementing the MHA, and progress of implementation of the MHA. An outline of these summary findings is presented in Figure 12.

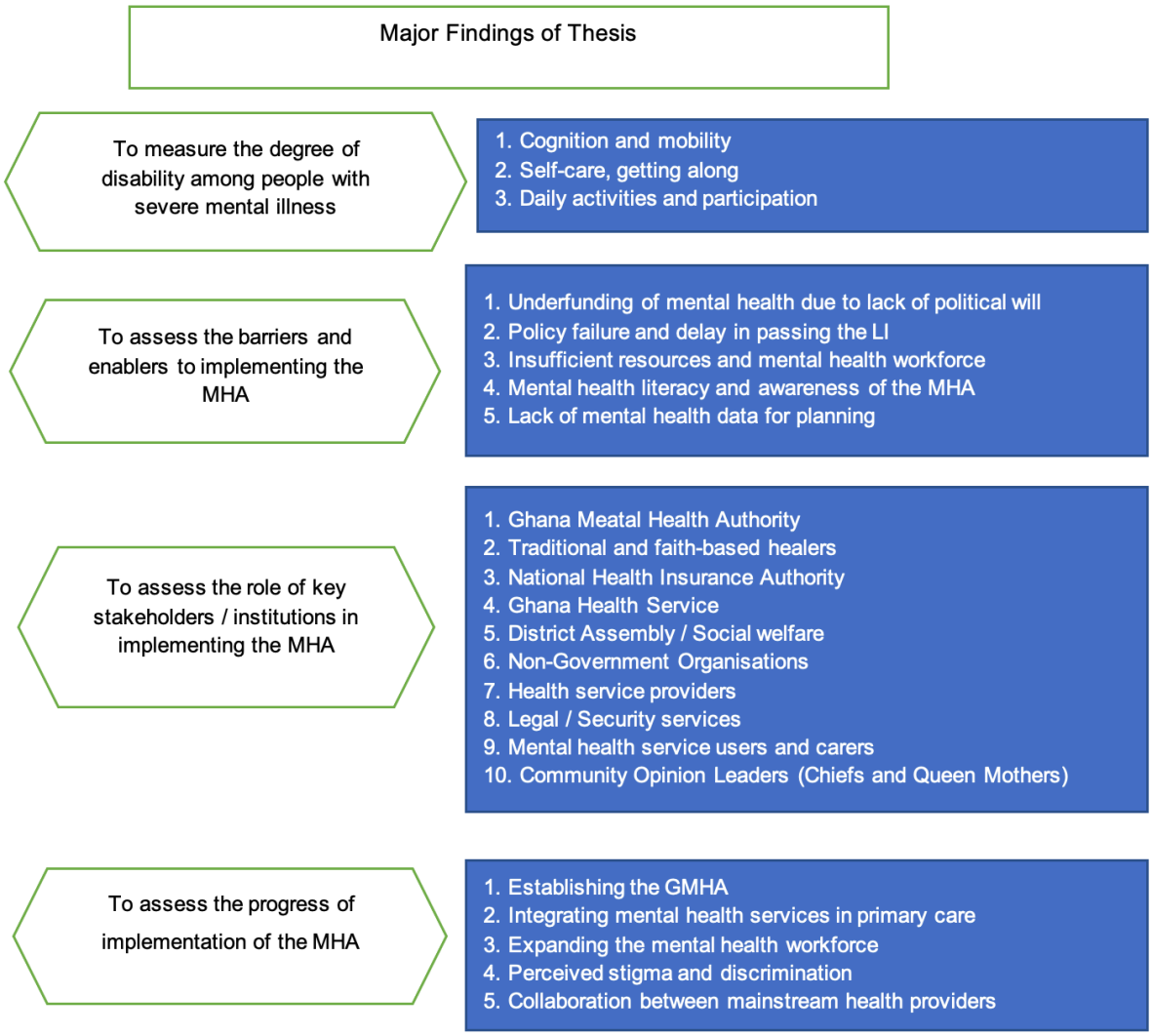

Figure 12: Summary of key findings

11.3 Key findings

11.3.1 Degree of disability among people with severe mental disorders

The quantitative research component assessed the degree of disability among people with severe mental disorders in the Kintampo North Municipality of Ghana and the knowledge of the MHA. Participants reported high functional disability on the WHODAS-12 score, indicating an inability to function well due to mental disorders (see section 4.5). This aspect of the study gathered baseline data from people living with severe mental disorders for future measurement of the impact of the MHA. The study also reported on the demographic characteristics of people living with severe mental disorders.

This Thesis reported that mental illness has a negative impact on the functional ability of people, which has also been demonstrated in previous studies elsewhere (Nwakasi et al., 2020). The functional disability was a consequence of poor access to mental health services. This assertion is supported by previous studies in other developing countries, which reported that mental disorders constitute a colossal global disease burden, with a large treatment gap (Chong et al., 2016; Kohn et al., 2004; Lund et al., 2012; Vigo et al., 2016; Vos et al., 2020; Whiteford et al., 2016; Whiteford et al., 2013; Whiteford et al., 2015).

The survey data highlights the important impact of employment and partner relationships on disability scores. Participants who were employed had lower median WHODAS-12 scores compared to those who were unemployed. This finding is similar to a study in Ghana examining the association between employment and psychological distress, which reported that increased psychological distress was correlated with increased unemployment. (Canavan et al., 2013). This explains the importance of work and relationships on individuals' overall mental health, hence, the need to implement the MHA to protect the rights of workers who are discriminated against because of mental illness. Modini and colleagues (2016) assert that work can help promote an employee's well-being (Modini et al., 2016).

Findings from this thesis also showed that a partnered relationship had lower median WHODAS-12 scores than those not in a partnered relationship (see section 4.6). This finding is consistent with a previous study, which suggested that married people report fewer mental health problems than unmarried (DeKlyen et al., 2006). Findings reported in Chapter 4 support those reported in these previous studies, and it is the first time this has been demonstrated in Ghana. Findings from the quantitative study presented in this Thesis underscore the importance of identifying possible triggers of mental ill-health, and the need to include these in public mental health education programs.

The data reported in the quantitative study indicated a general lack of a support network available for people with mental disorders in the Kintampo area. The limited support for people living with mental illness in Ghana resulted from a lack of Government investment of resources in mental healthcare; this has been reported in previous studies (Ae-Ngibise, Doku, et al., 2015; Read et al., 2009). This Thesis supports the findings of an earlier study that suggests that many people with mental disorders are not aware of the limited support services available because no systematic campaign to increase education and awareness has been undertaken by authorities, especially in deprived rural areas (Read et al., 2020). Although some social intervention programs exist for vulnerable groups in the area, these interventions lack penetration as most participants in the study were unaware of their existence and thus failed to access them.

Lack of resources in support of the MHA was identified as one major barrier for the low dissemination of the MHA. Social intervention programs such as the LEAP Program for people with disabilities, and the NHIS, which registers vulnerable people free of charge for health insurance, did exist in the study setting. However, only a few of the participants who were aware of these support systems had attempted to access them, and at the time of data collection, these participants were still waiting to receive any form of support. Earlier studies in Ghana have demonstrated the lack of support for people with mental health disorders and have recommended Government investment in this area to alleviate the suffering of people with mental illness (Awenva et al., 2010; Badu et al., 2018; Ofori-Atta, Cooper, et al., 2010; Roberts et al., 2014). An association was observed between participant gender and accessing help for their mental ill-health within the preceding 12 months (p=0.002) and registering or maintaining active membership on the NHIS (p=0.030). However, an insignificant association at 5% significance level was observed between diagnosis of mental illness and gender (see Table 4) as well as between healthcare received and gender (see Table 5).

11.3.2 Barriers and enablers to implementation of the MHA

In the last decade, the WHO has identified mental health as a priority for global health promotion and international development, to be targeted through evidence-based medical practices, health systems reform, and respect for human rights (Wildeman, 2013). Notwithstanding this, several barriers militate against these transformations. In Ghana, mental health reform and legislation are strategically focused on establishing an integrated community-based health model in line with the recently launched mental health policy (Ghana Mental Health Policy, 2019-2030). This policy seeks to integrate and expand access to quality mental health services, focusing on community-level services. The recent passage of the LI and subsequent launch of the 2019-2030 Mental Health Policy could be attributed to the sustained activism and advocacy of individuals and civil society led by the GMHA for improved mental health services. Although the mental health levy is yet to be established to provide sustainable funding for mental health. This Thesis identified a number of barriers as well as strategic enablers to the implementation of the MHA. These factors predominantly relate to failure of political leadership resulting in delay in passing the LI, insufficient data for service planning, inadequate funding and resources including mental health workforce training and low mental health literacy.

11.4 Health Financing

11.4.1 Underfunding of mental health services due to leadership failure

Lack of political will and commitment to adequate funding was a major theme inhibiting implementation of the MHA. This Thesis has established that the introduction of the MHA was a major milestone towards improving mental health services and protecting people living with mental disorders in Ghana. Similar observations describing the MHA as a significant step towards refining mental health services while ensuring human rights protection has been reported in Ghana (Doku et al., 2012; Walker, 2015; Walker & Osei, 2017). Notwithstanding this, a decade post introduction there has been slow implementation of the major legal requirements of the MHA. Major barriers identified by key stakeholders include underfunding due to lack of political commitment and leadership, failure to pass the LI that is necessary to provide the legal framework and establish the funding mechanism for implementation, insufficient mental health professionals, lack of advocacy and awareness of mental health, unlawful stigma and discrimination, harmful cultural practices and belief systems, and low mental health literacy.

Although the MHA has been described by mental health experts as a move to promote community-based mental health that protects the rights of persons with mental disorders (Doku et al., 2012; Walker, 2015), its implementation remains a significant challenge due to severe underfunding which is commonly identified in low-resourced countries as a key barrier preventing mental health policy implementation (Awenva et al., 2010; Lund, Mental, et al., 2010). Community-based care and integration with primary care will provide an opportunity to counter superstition about mental illness. It is anticipated that access to services will improve as patients and their caregivers receive treatment in their local communities. This is against the backdrop of the legal backing of the MHA, which mandates the state to establish a dedicated mental health funding system for sustainable mental health financing. In low-resource countries, poor governance and leadership have been identified as barriers to effective mental healthcare integration (Petersen et al., 2017). Akpalu et al., (2010) reported that to develop an integrated and accessible mental health service in Ghana, the State needs to reduce its dependency on the three main psychiatric hospitals and work towards integrating mental healthcare within established community health services.

Inadequate funding and low resource support have been a longstanding challenge for Ghana's mental health service delivery (Doku et al., 2012; Ofori-Atta, Read, et al., 2010; Roberts et al., 2014) and other low-income countries (Raja et al., 2010). The lack of interest and commitment by political authorities towards mental health in Ghana was a major theme raised by different participant groups, including policymakers, clinicians, community opinion leaders, service users and carers. Generally, there is a low commitment to mental healthcare in most low- and middle-income countries, reported in previous studies (Eaton et al., 2011; Hanlon et al., 2014; Lund et al., 2016), and which is disproportionate to the burden of disease in most Organisation

for Economic Cooperation and Development (OECD) countries. This is one reason why mental illness has not achieved proportionate attention and funding despite its high disease burden (Tomlinson & Lund, 2012). Whereas policymakers and NGO groups discussed long-term challenges such as lack of funding for implementing the MHA, mental health service providers were more concerned about the short-term or daily operational logistical needs such as lack of transport and medication for delivering mental health services. Mental health service providers are the key stakeholders responsible for the day-to-day implementation of the MHA, and their primary needs around resource provision were necessary for the implementation of the MHA. Indeed, unlike previous mental health policies that did not legislate the establishment of a dedicated source of funding for implementation (Awenva et al., 2010; Doku et al., 2012), the current MHA proposes the establishment of a quarantined mental health budget. However, the legal requirement for establishing this MHA levy has not been honoured, creating a substantial deficit in mental health resourcing which was identified as a major barrier to implementing the MHA, and consistent with findings from Awenva et al., (2010) and Doku et al., (2012) who advocated for committed leadership towards mental health.

Lack of means of transport to communities for mental health promotion programs and inconsistent supply of medications for patients was a major hindrance to implementing the MHA. It is worth noting that Governments in some developing countries have failed to prioritise mental healthcare due to factors including lack of importance of mental health on the public health agenda, complexities in the decentralisation of mental health services; challenges to implementation of mental healthcare in primary care settings, insufficient human and material resources as well as a scarcity of perspectives in mental health leadership (Saraceno et al., 2007). These factors have also been identified in the findings from this Thesis, and participants suggested sustained advocacy or lobbying of the Government to establish the legally mandated mental health fund with a dedicated funding source to ensure the implementation of the MHA. Increasing Government funding for mental healthcare and concerted public mental health education to mitigate negative cultural beliefs and practices affecting mental health will further improve the MHA implementation.

11.4.2 Insufficient resources and motivated mental health workforce

A trained and motivated workforce is central to the growth of any institution. Participants within each functional group of this study argued that health service availability had been impacted by the lack of trained mental health professionals. There would appear to be poor alignment between the drive to imbed mental health service delivery within public health and the skilled staff required. Resources are insufficient to educate, train, and recruit mental health professionals. Globally, a shortfall of the mental health workforce has been reported as a

significant setback for providing mental health service in many developing countries (Lund et al., 2016; Ofori-Atta, Cooper, et al., 2010; Roberts et al., 2014). Mental health services are provided by a multidisciplinary team involving psychiatrists, psychologists, mental health nurses, social and occupational workers, and TFHs (Ofori-Atta et al., 2018). Previous studies that assessed mental health services and legislation in Ghana had documented insufficient numbers of trained mental health workers and inequitable geographical distribution of mental health services as a significant barrier to accessing mental healthcare (Ofori-Atta, Cooper, et al., 2010; Roberts et al., 2014).

One key finding from this Thesis advocates for the distribution of mental health facilities, especially in the Northern part of Ghana, to bridge the geographical gap in service provision. It is interesting to note that the Government of Ghana has proposed plans to build two new psychiatric hospitals in the middle and northern belts of the country and also to redevelop the Accra Psychiatric and Pantang Hospitals. The workforce for mental health services provision is quite limited and falls below the recommended Sustainable Development Goals index value of 4.45 skilled health workers per 1000 population, or the global average of approximately 6.2 health workers per 1000 population (World Health Organisation, 2016). The MHA recommends further training of health professionals to augment the mental health workforce shortfall.

Data within this Thesis indicate that the failure by the Government to train more specialist mental health workers has resulted in a staffing deficiency. It can be argued that the institutionalised model of hospital-based care of the past required less specialist staffing compared to the proposed decentralised and integrated community care model. As previously highlighted, participant feedback suggests a dichotomy between the prescribed model of care and the development of the required workforce. Over the years, this trend is attributed to a lack of Government commitment to training mental health professionals to scale up mental health services across all regions in Ghana. To overcome this challenge, as indicated in this Thesis and already reported by previous studies (Dixon, 2012; Doku et al., 2012), central Government and strategic donor organisations need to prioritise mental health by providing funding for training more professionals that will facilitate the implementation of the MHA.

The introduction of the MHA has facilitated an appreciable improvement in the number of the mental health workforce. There have been major mental health training reforms ongoing that are targeted at increasing the specialist mental health workforce and making mental health part of all clinical training regardless of specialisation. More so, paraprofessionals and generalist allied health professionals are being upskilled in mental healthcare for the eventual integration of mental health services in primary healthcare. Mental health workforce

development has been slow. Task-shifting has been criticised in favour of task-sharing, as previous studies and initiatives have demonstrated the possibility of upgrading community health staff's skills such as nurses, technical officers, and other volunteers to detect and refer cases of mental illness for advance care (Eaton et al., 2011; Lund et al., 2016; World Health Organisation, 2005). Due to the prevalence of mental illness and the undersupply of mental healthcare workers, it is important that all healthcare workers have some awareness and capacity to identify signs and symptoms of mental illness and manifestations of general psychological disorders to bridge the mental health treatment gap (Agyapong, Farren, et al., 2016). In the same vein, it is crucial that mental health workers can identify the signs and symptoms of physical illnesses in their practice for effective primary healthcare. Therefore, upskilling non-specialist mental health workers is imperative for effective integrated health services.

Improvement in the condition of work for the few mental health workers was a major concern for the mental health providers who participated in the study. This Thesis identified no clear career progression pathway for staff already in the mental health sector in Ghana, which was cited as further resulting in high staff attrition from the overstretched mental health workers to the general healthcare sector. These findings are similar to the Jack et al., (2013) study that reported demotivation factors for mental health professionals to include lack of resources and fewer opportunities for career advancement within the mental health field. Recruitment and retention was reported as a factor impacting on mental health workforce distribution. The need for ongoing training of mental health and allied professionals is imperative for facilitating the implementation of the MHA and maintaining the highest standard of mental healthcare.

11.4.3 Expansion of the mental health workforce

The introduction of the MHA facilitated the expansion of the mental health workforce by the appointment of RMHC and regional mental health sub-committees to administer and supervise mental health activities across all regions in Ghana. These appointments resulted in an increase in mental health service provision across all regions and districts. Access to mental health services had improved due to the deployment of mental health workers across the country. This Thesis also identified that access to mental health information had improved as attention shifted from institutional-based care to community-based care. Discussion on mental health workforce has always been limited to psychiatrists and nurses, neglecting other allied mental health professionals. As highlighted by Doku and colleagues (2012), specialities such as forensic, child and adolescent, learning disability and addiction psychiatry are not available in Ghana and need to be addressed to facilitate the implementation of the MHA. Although the mental health workforce has expanded, there is still a need to systematically

address matters relating to staff recruitment, retention and continuing career development of mental health workers.

11.5 Leadership and Governance

11.5.1 Policy failure and delay in passing the LI

In Ghana, poor mental health service provision is believed to result from inconsistent mental health policy investment over the years. Several outdated practices and structural difficulties impeding the implementation of mental health policies in Ghana persist (see section 7.5). Strategies were identified to overcome these practices and barriers following the WHO recommended guidelines for implementing mental health policies (World Health Organisation, 2005). As in many developing countries, Ghana's mental health services are underdeveloped (Bird, Omar, Doku, Lund, Nsereko, & Mwanza, 2011; Lund et al., 2016; Patel et al., 2018; Tomlinson & Lund, 2012). This Thesis further confirms reports of the low political priority of mental health in Ghana due to a lack of political commitment and leadership in implementing the MHA and the need for key stakeholders such as mental health service users, mental health professionals, policy makers and NGOs to work together to apply pressure on Government.

Participants identified the delay in passing the LI and enforcing it as a major impediment to the MHA implementation. Previous studies have identified mental health policies in developing countries to be limited with weak implementation trajectories (Lund, Mental, et al., 2010; Walker & Osei, 2017). This perhaps, confirms the argument by previous studies that many low-income countries have weak states and strong societies, which explains the partial or failed implementation of many policies (Gilson & Raphaely, 2008; Walt & Gilson, 1994). Lack of political commitment and leadership was a repeated theme in reference to the delay in passing the LI and subsequent establishment of the legislated mental health fund. It is evident that the majority of the current MHA provisions are consistent with the WHO's mental health policy objectives for coordination and management of mental health services, promoting de-institutionalisation and creating integrated community-based mental health services (Doku et al., 2012).

Weak or ineffective implementation of the MHA is really an important issue that emerged from this Thesis. Previous studies have confirmed that the implementation of Government policies in Ghana is weak, not just mental health but also general policies as previously documented (Doku et al., 2011). The reason for the poor implementation of the MHA appears to be a failure in securing financial resources. There is no available economic data on the burden and costs of mental disorders at the national level. There is also a lack of advocacy and a prevalence of negative attitudes about mental illness. The WHO (Freeman & Funk, 2007) has previously

recommended that Governments constitute national advisory bodies with the mandate to oversee the implementation of mental health policies. It is possible that this recommendation informed the establishment of the Mental Health Board as a structure within the MHA to perform the function of reviewing, monitoring and evaluating the MHA implementation. Nonetheless, the Mental Health Board is organisationally crippled and severely restricted due to inadequate funding.

11.6 Health information System

11.6.1 Lack of mental health data for planning

Another theme that emerged from this study is the lack of mental health data for planning. Evidence from research data is needed to inform mental health policy implementation (Roberts et al., 2014). It is clear from this study that there is insufficient data in Ghana on the burden of mental illness and its impact on economic development. Roberts et al., (2014) report that only one per cent of all publications on health focuses on mental health. This lack of epidemiological data on mental health acts as a barrier to justify Government investing resources in mental healthcare. Empirical data on the burden and impact of mental illness on Ghana's economic development will support calls for implementing the MHA.

11.6.2 Mental Health Literacy and Awareness of the MHA 846

The survey data and the key stakeholder interviews indicate a general lack of knowledge and awareness among the participants about the MHA. Whereas most service users did not know of its existence, community opinion leaders and some health workers had limited knowledge, suggesting that the GMHA would have to direct their education programs to the learning needs of diverse groups. This lack of knowledge about the legal framework that provides guidelines for mental healthcare extends to a general lack of awareness about mental health interventions aimed at promoting wellness; this has been reported in Ghana and other low-income countries (Badu et al., 2018; Roberts et al., 2014; Sipsma et al., 2013). Public awareness of mental health is low worldwide (Patterson et al., 2018). In this Thesis, participants revealed a lack of awareness of the existence of the MHA, which negatively affects its implementation.

Lack of knowledge and awareness of individual rights and responsibilities under the MHA holds back the potential for more widespread advocacy in implementing the MHA among the public and especially from service users and carers' perspectives, potentially acting as a significant barrier to demanding access to mental health services. This assertion is confirmed

by a previous study that emphasised the co-morbidity of illiteracy and mental illness and linked this to an increased likelihood of experiencing human rights violations, as illiteracy can adversely affect the ability of a person to seek formal supports (Mfoafo-M'Carthy & Huls, 2014). Additionally, the low literacy rate within certain sections of the Ghanaian population was also considered a significant barrier to knowledge acquisition about the MHA (see section 7.11). A consequence of the lack of knowledge of the MHA has resulted in many people with mental disorders, especially those residing in deprived rural areas, not getting access to the mental health services they need. This highlights the need for all key stakeholders to scale up mental health services throughout Ghana to improve access, which could reduce disability associated with the lack of treatment services.

In this Thesis, most end-users did not understand the apparent barriers to implementing the MHA, which was partly attributed to a lack of awareness due to poor dissemination of the mental health policy. Poor penetration of the MHA implies that people are not informed sufficiently to advocate for their rights to treatment. Increasing the mental health literacy of key stakeholders and the public in general is paramount to embedding the MHA and improving mental health service delivery. This Thesis identified that the MHA implementation may be achieved with renewed Government effort in addressing the resource gap in funding mental healthcare. Increasing mental health literacy as a way of overcoming policy implementation challenges is necessary for the acceptance of policy reform by end users. Apart from inadequate funding from Central Government which is key for raising awareness about mental health and improving mental health literacy, private entities including NGOs have a social responsibility to provide advocacy programs to supplement Government efforts. Awareness creation is a key implementation strategy for achieving positive implementation outcomes as postulated by the LHPS (Oh et al., 2021).

This Thesis demonstrates a general lack of knowledge and awareness due to poor dissemination of information to stakeholders and the general public. According to the 2010 Ghana population and housing census report, approximately 24 per cent of the Ghanaian population have no formal education and 33 per cent of people who reside in rural areas have never attained formal education (Ghana Statistical Service, 2021). Lack of formal education and poor low mental health literacy could be a barrier for the lack of awareness of the MHA. Therefore, if policies are formulated at the Governmental level unless the information reaches out to the mental health service users to understand, there might not be any greater impact or difference in health service users and carers' lives.

Also, low mental health awareness has a negative impact on providing safe and effective mental health services in Ghana. Possible factors accounting for this lack of awareness about

mental health issues include inadequate advocacy, especially in the rural areas, and more importantly, the lack of importance attached to mental healthcare in Ghana (Awenva et al., 2010; Doku et al., 2012; Roberts et al., 2014) and other low resourced countries (Eaton et al., 2011; Lund et al., 2011; Lund et al., 2016).

The lack of knowledge about the MHA was not limited to mental health service users but included critical stakeholders, and this was a striking finding from this Thesis, which reports limited knowledge and awareness of the MHA statutory requirements among key stakeholders. Lack of appropriate promotional resourcing and over-reliance on the traditional media such as TV and FM radio over targeted community outreach strategies was considered to have contributed to the inadequate knowledge penetration. The majority of the Ghanaian population resides in rural areas with limited access to mainstream media (Ghana Statistical Service, 2021). An appropriate strategy might be to use community outreach programs to reach out to most people rather than being over-reliant on mainstream traditional media. As data from this research demonstrates, although Government has decentralised mental health services to the regions, provided RMHC and is in the process of integrating mental health services into a community model, the necessary transport resources have not been provided to allow the workers to integrate their services completely in primary healthcare. The implication is that the Government and other relevant health authorities have to provide the necessary means of transport for mental health workers to disseminate information about the MHA to people in the rural areas who may not have access to mainstream media. In Ghana, as in other parts of the world, poverty and geographical locational disadvantages is a serious issue. Evidence suggests that people living in rural areas in Ghana, including those living with mental illnesses generally have lower-incomes culminating in reduced access to services, such as health, education and transportation network (Ae-Ngibise, Doku, et al., 2015; Mfoafo-M'Carthy & Grischow, 2020).

It was surprising that close to a decade since the MHA was introduced, some key stakeholders, including mental health services providers, policymakers, Government departments, and community opinion leaders responsible for implementing the MHA, were unaware of the legislative details (see section 7.9). This finding is similar to that reported by Anokye and colleagues that there is insufficient knowledge of mental health legislation among health workers and other key stakeholders in Ghana (Anokye et al., 2018). In this regard, the GMHA will have to intensify public education among key stakeholders including mental health service providers to be equipped with the necessary knowledge of the MHA that will facilitate the MHA implementation. Globally, society advocacy and activism have been demonstrated to play an essential role in highlighting the needs of people with mental illness (Drew et al., 2010; Funk et al., 2006). As reported in a previous study (Petersen et al., 2017), public health

education, advocacy campaigns and sustained activism could prove to be a strategic measure for improving mental health literacy and increasing patients' assertiveness to demand quality mental health services. Improvement in mental health literacy could speed the implementation process of the MHA, and this concept emerged as one key strategy discussed in this study. Stakeholder engagement, including those at the community level, is paramount in promoting mental health awareness to facilitate the overall implementation of the MHA.

11.6.3 Perceived reduction in stigma and discrimination

Another reported achievement of the MHA discussed by some stakeholders was that anti-stigma campaigns and advocacy facilitated by the introduction of the MHA did result in reducing stigma and discrimination. This perceived decline of stigma and discrimination, which is yet to be measured quantitatively, was attributed to the increased advocacy of mental health activities and the re-alignment of mental health service provision in some primary health facilities. The introduction of the MHA has brought about a new anti-stigma and discrimination awareness program that is being facilitated nationally by the GMHA. Data from this research suggest that the MHA has generated a national conversation focused on stigma and discrimination against people with mental illness.

Stigma and discrimination have been recognised as one of the most important mental health reform issues nationally (Edwards, 2014; Walker & Osei, 2017) and internationally (Badu et al., 2018; Whiteford et al., 2013). It was suggested that the partly implemented integrative mental health service within primary healthcare in Ghana and the advocacy programs undertaken by the GMHA have resulted in stigma decline as more people are becoming aware of the nature of mental health issues. While some key policymakers and community opinion leaders had argued that stigma and discrimination against people with mental illness had declined due to implementation of aspects of the MHA, some mental healthcare providers and service users at the community level had a contrary opinion, contending that though stigma and discrimination are declining, further decline would have been achieved if more resources had been channelled to address stigma and discrimination effectively. Consequently, the MHA's proposition for establishing Mental Health Tribunals was described as a significant strategy for protecting human rights, especially against stigma and discrimination. This contradiction between policymakers and service users concerning the reduction in stigma suggests the need for the GMHA to rigorously evaluate their education programs directed at reducing stigma and discrimination.

11.7 People and institutions as stakeholders for implementing the MHA

As identified in the LHPS framework, engagement of stakeholders such as policymakers in the implementation process and building infrastructure responsive to policy could improve policy implementation decisions (Oh et al., 2021). The LHPS is an important policy implementation model because it highlights an iterative consideration of implementation strategies that are relevant for achieving the desired effect of a policy change that helps bridge the policy to practice gap. Findings from this Thesis showed that key stakeholders play a central role in facilitating the MHA implementation, yet there appears to be no broader consultation and collaboration among stakeholders in efforts to implement the MHA. It was evident from the Thesis that mental health stakeholders must work collaboratively to support the implementation of the MHA. Previous studies of the challenges facing mental health service delivery in Ghana suggests the need for broader stakeholder consultation and collaboration, including both users and providers of mental health services to successfully implement mental health policies (Awenva et al., 2010; Nyame et al., 2021). Stakeholders such as GMHA, TFHs, NHIA, MoH/GHS, District Assembly, Social welfare, NGOs, health service providers, legal services including Ghana Police Service, Prison Services and CHRAJ, service users and community opinion leaders should coordinate to ensure the MHA implementation.

11.7.1 Ghana Mental Health Authority

As provided in the MHA, the GMHA is responsible for providing policy directions that will facilitate the implementation of the MHA and associated mental health reforms. Also, the GHMA is to promote mental health and provide humane care including treatment and rehabilitation in a least restrictive environment; and ensure culturally appropriate, affordable, accessible and equitably distributed, integrated and specialised mental healthcare that will involve both the public and the private sectors (Mental Health Act 846, 2012). The GMHA has so far performed well in scaling up nationwide mental health services albeit a lack of financial resources to effectively execute its mandate.

11.7.2 TFHs in mental healthcare

In Ghana and other African countries, mental healthcare has been influenced by complex and competing socio-political and economic processes (Amuyunzu-Nyamongo, 2013; Kpobi & Swartz, 2019). Within an African context, concepts of health and healthy have always emphasised the state of ‘wellness’ as being the complete physical, social, mental and psychological well-being of the individual (Gee et al., 2014; Khumalo et al., 2012). This study

underscored the critical role of TFHs in mental health service provision, attributing the situation to the socio-cultural and religious belief systems and insufficient and poor access to mental health services.

The role of TFHs in mental healthcare has been reported worldwide (Arias et al., 2016; Barimah, 2013; Burns & Tomita, 2015; Gureje et al., 2015; Kpobi & Swartz, 2019; Patel, 2011). Studies on the importance of TFH services in providing psychosocial care have reported that in jurisdictions where formal mental health services are limited or unaffordable, TFHs provide a significant source of backup mental healthcare access to service users (Drury, 2020; Nortje et al., 2016; Sessions et al., 2017). It was evident from the stakeholder interview that whereas some people seek mental healthcare from TFHs because of cultural belief systems about causation and the perceived effectiveness of treatment outcomes for mental illness, others do so because of limited biomedical mental healthcare availability and lack of mental health knowledge. This finding has been reported elsewhere (Khoury et al., 2012).

Moreover, shared values and belief systems about the aetiology of mental illness and the explanatory models of disease causation account for the broader use of TFH services (Ae-Ngibise et al., 2010). Lack of access to mental health services due to weak or insufficient public mental health funding in Ghana reported in previous studies (Awenva et al., 2010; Doku et al., 2012; Raja et al., 2010; Roberts et al., 2014) also explains the reason for the use of TFHs as found in this Thesis.

The provision of mental health services is complicated by the existence of TFHs, who are often the first point of call for people seeking support for mental health conditions. Although there has been little research about the effectiveness of TFHs in terms of health outcomes, many people continue to seek their services. There has been documentation of harmful practices by some of the TFHs (Ssengooba et al., 2012), however, these harmful practices may not be happening at all of the traditional and faith-based healers' camps as reported by this Thesis. TFHs are often well embedded in the community and are seen to understand the cultural and community context, and there are accounts of helpful synergistic work (Bartlett, 2010). A careful and well thought through liaison with TFHs may expand the health human resource available for people living with mental disorders. It is established that mental health is not just a health issue, it also links to the other sectors of employment, education, social welfare, and criminal justice system. Collaborative local linkages with other local sectors are needed in order to promote mental health, prevent illness and address mental disorders (Jenkins et al., 2002).

A group of service users and carers in this research reported the lack of access to conventional mental health services, which makes them seek the services of TFHs (see section 8.8). By

default, therefore, TFHs substitute for the deficits in health service financing and weak public health service provision for people living with mental illness due to lack of Government resourcing. This Thesis has confirmed the findings of previous studies that there are insufficient mental health services (Adu-Gyamfi, 2017; Awenva et al., 2010; Doku et al., 2012; Ofori-Atta, Read, et al., 2010; Roberts et al., 2014), hence the justification for building collaboration with TFHs who are already informally providing mental health services to fill in the treatment gap (Ae-Ngibise et al., 2010; Asamoah et al., 2014; Ofori-Atta et al., 2018; Patel, 2011). TFHs as key players in scaling up mental healthcare and closing the treatment gap has been reported elsewhere (Patel, 2011), hence the need for a collaborative model of care that acknowledges the role of TFHs and provides a framework to govern their practice (Campbell-Hall et al., 2010). Mental health workers work with minimal resources, supervision, and support; hence TFHs are often the only readily available resource for some people at the community level, with attendant human rights abuses such as restrictive and coercive treatment.

While most participants acknowledged the important role that TFHs have and could continue to play in mental healthcare, they also noted the human rights abuses that have been linked to such practitioners at some of the TFH centres. To some extent the human rights concerns regarding ill treatment and abuse in many centres has been addressed in more recent years and while these continue, they are not currently as common and widespread. However, there is an ongoing need for this to be monitored and addressed within a formalised governance structure, given one had not previously existed. Participants were firmly in favour of measures designed to ensure the cessation of all inhumane practices in the healing centres. These documented human rights abuses of people living with mental illness in Ghana and other low- and middle-income countries have been increasingly reported (Drew et al., 2011; Ssengooba et al., 2012).

Mental health service users and carers who had experienced human rights violations by some TFHs reported no health benefit from the maltreatment practices of restrictive treatment, chaining, flogging and force-fasting. It must be acknowledged that some mental health service users in the current study did not support the use of TFHs to provide mental health services due to what they described as a lack of effectiveness of the services provided and the historical systematic human rights abuse, which have also been reported (Read, 2012). Some of these human rights violations have been reported by the Human Rights Watch and other studies (Drew et al., 2011; Edwards, 2014; Ofori-Atta et al., 2018; Patel et al., 2018; Ssengooba et al., 2012). The MHA was introduced partly to address these human rights abuses while promoting community-based mental healthcare in place of institutionalised care. As legislation, the MHA covers the assessment, treatment and rights of people with a mental health disorder. As

previously discussed, despite the increasingly available mental health services facilitated by the MHA introduction, TFHs remains highly valuable in addressing mental health problems in Ghana due to the people's socio-cultural orientation (Ae-Ngibise et al., 2010; Barimah, 2013; Kpobi & Swartz, 2019).

In contrast to an argument by some of the research participants in this study, a recent cluster randomised controlled trial on the effect of collaborative care between TFHs and primary healthcare workers on psychosis outcomes in Nigeria and Ghana reported that collaborative shared care delivered by TFHs and orthodox healthcare providers for people with psychosis was clinically effective and cost-effective (Gureje et al., 2020). As a collaborative intervention study, the findings by Gureje et al., may not be surprising because of the regulation and supervision that would have been put in place for such a trial would invariably serve as a check on the activities of TFHs and might also promote good practice. This finding affirms the important need for a joint care model for people living with mental illness since it affords the opportunity of improving mental healthcare in settings with low resources, such as Ghana.

A number of participants within this study asserted that bringing together orthodox and TFHs into an integrated clinical model would provide the necessary transparency of practice to protect against maltreatment and inhumane care, thus, promoting access to enhanced mental health service delivery. Although there have been longstanding calls for collaboration between conventional mental health workers and TFHs (Green & Colucci, 2020; Kpobi & Swartz, 2018), minimal investigation about how such collaboration works in practice and how best to construct effective partnerships between these different healthcare providers with distinct healing traditions (Ae-Ngibise et al., 2010; Kpobi & Swartz, 2018, 2019; Van der Watt et al., 2017). Therefore, nurturing collaborations with TFHs is crucial in effectively planning and implementing mental health services as an advocate, as emerged from this Thesis which has also been widely recommended (Ae-Ngibise et al., 2010; Read, 2019; Wildeman, 2013). This is believed to prevent human rights abuses and promote holistic mental health treatment.

Unregulated use of restraints by TFHs is illegal under the MHA (Ghana Mental Health Authority, 2018); notwithstanding this, coercive practices still exist, although there is evidence of these inhumane practices reducing, especially in areas where the GMHA has had an impact through pockets of interventions. The need for formal regulation and state-enforced governance of TFH practices presented a consistent theme across the participant groups in this Thesis. The fact that there is no central register of TFHs presents a significant challenge to the GMHA in implementing regulatory practice guidelines. It is worth noting that the formal recognition of TFHs and the subsequent development of guidelines by the GMHA to regulate

practices at healing camps indicate a commitment by the GMHA to work with TFHs to provide collective and collaborative mental healthcare to service users. The guidelines, however, will need to be enforced by the GMHA to ensure strict compliance. To protect against future inhumane care, TFHs will need to be formally registered, provided with appropriate training and required to meet endorsed practice standards.

Within the Ghanaian context, as with other developing countries, future focus will need to be directed toward contemporary efforts to integrate aspects of TFHs beliefs and practices among Indigenous Ghanaians with medical and psychiatric treatment programs. Creating a shared perspective will require orthodox clinical service providers to overcome their scepticism concerning scientifically unproven TFH treatments for both medical and psychiatric disorders. The challenge is how to find concepts and methods that can accommodate both systems without violating the fundamental beliefs of either practice. Common ground between mental health workers and TFHs to provide mental health services in a synchronised form devoid of suspicion and animosity would positively impact peaceful collaboration. The challenge is how to develop sustainable strategies that allow for development of a Ghanaian pluralistic and biomedical dualism of mental healthcare without violating the fundamental beliefs of either practice.

Prayer camps are found across the length and breadth of Ghana and are well utilised by people living with mental illness (Asamoah et al., 2014; Osafo, 2016). As reported in this study, some of the prayer camps have established collaborative links with formal mental healthcare service providers where patients' referral is two-way (see section 5.6). Formalising collaborative arrangements between prayer camps and conventional health services to support and treat people with mental health problems could provide opportunities to use existing resources efficiently to improve mental health treatment outcomes. It appears that collaboration between the conventional mental health sector and church pastors will be less complicated because of the already established engagement reported by this study in section 5.7.

The recognition of TFHs in the new mental health reform agenda as the informal or traditional pluralistic community mental healthcare providers will further strengthen long-lasting relationships among healthcare providers to construct steps that would define future collaboration and partnership. To facilitate the MHA implementation, it is crucial to explore the nature of collaboration that could work between conventional mental healthcare providers and TFHs. Collaboration could be in the form of community outreach, home and church visits, education, support with medication supply, fundraising, and social support activities. Institutional support and commitment, non-judgemental attitude and respect for TFHs position,

and regarding each other as partners might make collaboration successful. Nonetheless, some studies have also expressed reservations about the success of such collaboration, citing the possibility of unequal political and cultural power relations, which may result in forceful assimilation of one system on the other that tends to collapse the already weaker system (Kwasi, 2007; Van der Geest & Krause, 2014).

The role of TFHs in the form of cultural and religious-specific psychotherapy utilising religious concept and ritual has been established as a strategy to recovery (Eshun & Gurung, 2009). This has been demonstrated to work in some Islamic communities where Islamic concepts and rituals are applied as part of the recovery process (Keshavarzi & Haque, 2013; Weatherhead & Daiches, 2010). However, psychotherapy as a western construct does not necessarily fit well within the African psyche, as mental health services continue to focus on acute care using medical models. Perhaps, this study provides an opportunity for faith healing in the form of religious-specific psychotherapy as an adjunct to recovery, while western services provide assessment and treatment of acute symptomatology.

Consensus building and negotiating between some mental health service users and TFHs will have to be addressed to bring mental health service users and carers who appear not to appreciate the value of the services of TFHs to accept the role of these healers. The implication is that mental health facilities should be adequately resourced to provide services for people living with mental illness whose preference is to receive conventional mental healthcare.

11.7.3 The National Health Insurance Authority

The NHIA as a key stakeholder has a key role in ensuring psychotropic medication supply (see section 9.7). The shortage of medication for people with mental illness was a consistent theme discussed extensively as a major obstacle to implementing the MHA. Medication is an integral part of treatment for many people living with serious mental illness. Medicines can reduce symptoms so that other methods of treatment can be applied. In principle, public mental health services in Ghana are free, including clinical consultation, medication and hospital inpatient care. However, mental health services are not covered under the NHIS. Notwithstanding this, there has been an inconsistent supply of psychotropic medication resulting in patients procuring medicine at their own expense from private pharmacies (Oppong et al., 2016; Roberts et al., 2014). According to a number of participants, this arrangement persists with the introduction of the mental health reforms and there has been no evidence of Government attempting to resolve this policy conflict (see section 9.7).

Access to psychotropic medicines requires coordinated effort at multiple levels to match the demand from service users and supply from the healthcare system. The essential medicine list covered by the NHIS does not include the important psychotropic medicines, and service users have to procure these medicines from private sources. Some participants suggested that all commonly used medicines to treat mental illness be added to the essential medicines list under the responsibility of the NHIS. This would eliminate the confusion of no central procurement system for psychotropic medicines. Currently, procurement involves multiple sources including the MoH, GHS, Central and Regional Medical stores, teaching hospitals, psychiatric hospitals and donor organisations. Entrusting the responsibility of psychotropic medicine procurement under NHIA was deemed necessary to mitigate the perennial shortage of medication and ensuring accountability regarding the distribution of medication. Participants identified this to have the potential of encouraging private sector participation in health insurance schemes to increase access to mental health services.

11.7.4 District Assembly and Social Welfare

The District Assemblies were identified as an important stakeholder in supporting the implementation of the MHA. One of their major responsibilities is to ensure that people living with mental disorders who are vagrant are sheltered, treated and reintegrated into their families and communities (see section 10.3). This key legal requirement in the MHA has not been implemented because of the failure of the Government to fund the Assemblies to accomplish this important duty. This study aligns with the findings of Tawiah and colleagues, who identified a high level of vagrancy amongst people with mental illness as a result of family and community rejection (Tawiah et al., 2015). The implication is that any strategy to get people with mental illness off the streets and reintegrate them will have to be negotiated with close family and community leadership. Although the District Assemblies are underfunded, part of the common fund allocated from the central Government can be used to construct shelters to serve as rehabilitation centres and accommodation for people living with mental illness who are homeless. Further work is required to help the District Assemblies understand the important role mental health literacy plays in preparing communities to accept people with mental illness back into their community and support their reintegration.

The SWCD is a key stakeholder that provides financial support in quarterly cash transfers under the LEAP program to people with disabilities and other vulnerable groups. Although people with psychosocial disabilities were not initially recognised under the LEAP program (Doku et al., 2012), there is evidence to suggest that there has been a change in policy allowing for people with enduring mental health to be enrolled in the LEAP programme. This

is an important change that will lessen the financial burden on many mental health service users and their carers.

11.7.5 Non-Government Organisations

NGOs and community opinion leaders play critical roles in advocating and supporting mental health reform. NGOs such as BasicNeeds Ghana, provide livelihood support programs and empower people with mental illness to demand better health services from health authorities (Cohen et al., 2012). This Thesis found that a number of NGOs were instrumental in providing funding, advocacy and delivery of logistics to facilitate community mental health outreach programs. Further to this, data within this Thesis identified that NGOs play a critical role through providing technical support and advice to Government on implementation of mental health reform.

11.7.6 Mental health service providers

Participant feedback within this study identified the need for Government to increase urgency in integrating mental health services into primary healthcare. As findings from other studies conducted in low-resource countries (Eaton et al., 2011; Lund et al., 2016; Ofori-Atta, Cooper, et al., 2010; Saxena, Thornicroft, et al., 2007) indicate, operational resources such as transportation have always been a challenge for community outreach service provision. To overcome further barriers to implementation, improving the mental health literacy of the general public will need to remain a high priority for mental health service providers.

11.7.7 Legal and Security Services

The legal and security services such as the Judiciary, CHRAJ, and the Police Service are responsible for protecting the rights of persons living with mental illness. Unfortunately, further education needs to be provided to these key stakeholders if they are to fully understand their role and responsibilities under the MHA. This was also identified in a previous study by Awenva et al., (2010). The Police Service and the Judiciary are required to refer accused people who exhibit symptoms of mental illness for medical assessment before committing them to stand trial. It was evident from the interviews that a number of these key stakeholders do not understand their role and new responsibilities under the MHA. This further reiterates a need for a comprehensive education program for these stakeholders to understand their role and responsibilities in protecting people living with mental illness who may come in contact with the law. If the security agencies do not understand their role, the positional power that they hold will leave people with mental illness at risk from institutional abuse and infringement of their individual rights. There is a general lack of enforcement of laws in most developing countries, including Ghana (Omar et al., 2010), to prevent violation of the rights of persons

living with mental illness, the security services need to ensure strict compliance of the MHA. This presupposes that the security services first need to understand the MHA and their roles under the MHA before they can enforce implementation of the MHA.

11.7.8 Mental health service users and carers

Mental health service users and carers have a key responsibility to participate actively in mental health advocacy and demand improved mental health services. The formation of self-help groups for mental health advocacy was another key strategy for supporting members within the group. These self-help groups have proven effective in supporting members' interests and demanding better mental health services in Ghana (Cohen et al., 2012) and other countries (Gona et al., 2020). This Thesis identified that self-help groups usually share lived experiences, and members serve as peer educators in mental health promotion.

11.7.9 Community opinion leaders

The Ghanaian traditional community structure has leaders whose opinions on specific matters are highly respected by the community members (Asante et al., 2013). As described in section 10.7, community opinion leaders especially Chiefs and Queen mothers have a social responsibility of protecting people living with mental disorders through issuing directives during community durbars as reported in this Thesis. Public declarations and support for people with mental disorders by Chiefs and Queen mothers would help to reduce stigma and discrimination against people living with mental illness. As the local authority at the community level, these leaders have the duty of rallying key stakeholders to support people living with mental illness and ensuring people with mental ill-health get required treatment through various advocacy programs.

11.8 Service delivery and progress of MHA implementation

Five major outcomes have been achieved following the introduction of the MHA. These include: the establishment of the GMHA; integrating mental health services in primary healthcare; expanding the mental health workforce, including regional mental health sub-committees; impact on stigma and discrimination; and a formalised collaboration between the GMHA and TFHs. These outcomes were regarded as important progress towards implementing the MHA since its introduction in 2012.

11.8.1 Establishment of the GMHA

One of the major achievements resulting from the introduction of the MHA is the establishment of the GMHA with a Governing Board. The introduction of the MHA facilitated the establishment of the GMHA and the Governing Board as an independent body under the MoH. As a regulatory body, the GMHA has the primary responsibility of ensuring quality mental health service is provided by implementing the MHA. Invariably, this significant milestone in the history of mental healthcare in Ghana also came with staff appointments, including district, regional and national mental health coordinators, to facilitate mental health service delivery.

11.8.2 Integrating mental health services in primary healthcare

The partial integration of mental health services into primary healthcare was another milestone achieved by introducing the MHA. The WHO proposed integrating mental health into primary health (World Health Organisation, 2008) to increase access to mental health services. This conforms with the service delivery component, one of the WHO 7 HSBB that recommends effective health delivery services to bridge the large treatment gap. The partial integration of mental health services in primary healthcare was strategically implemented, which was a major finding of this Thesis. Despite some participants preferring additional standalone psychiatric hospitals to be constructed (see section 7.6), most participants identified the integration of mental health into primary healthcare as strategic for implementing the MHA.

It is evident that the establishment of mental health services in other health facilities and the introduction of paraprofessionals have directly increased access to mental health services. This integrative and inclusive healthcare model will be more likely acceptable and accessible for people living with mental disorders. The findings in this Thesis indicate that integration of mental healthcare is being strategically implemented, which is similar to what has been reported elsewhere that mental healthcare, delivered in primary healthcare settings, is more accessible and acceptable for service users and carers (Funk et al., 2008; Sorsdahl et al., 2021; Wakida et al., 2018). Nonetheless, as reported in this Thesis, improving access to mental health services has not resulted in affordable mental healthcare because of the limited implementation of the MHA, as evidence by the inconsistent supply of psychotropic medicines at the health facilities. The WHO HSBB demonstrate the need to ensure consistent medication supply for patients to improve access and treatment outcomes.

One of the purposes of introducing the MHA is to promote community-based mental healthcare, which is more likely to have better treatment outcomes while maintaining social and community integration. As reported by other studies, integration of mental health in

primary healthcare is more acceptable because it reduces the risk of people being exposed to human rights violations as well as stigma that is often associated with standalone psychiatric institutions (Egbe et al., 2014; Freeman & Pathare, 2005; Kohrt et al., 2020). This reported reduction in stigma is anchored on the fact that primary healthcare services are not associated with any specific health disorder; therefore, stigmatisation and discrimination usually associated with mental illness will be less prevalent and would promote utilisation of mental health services (Kohrt et al., 2020; Sapag et al., 2018).

For effective integration of mental health in primary healthcare, there must be periodic support supervision from psychiatrists and psychiatric nurses at the regional, district and community level to provide technical support where necessary. Nonetheless, the shortage of specialists, mental health workers and lack of funds for transportation implies that in health facilities where training for primary care takes place at district and community levels, regular supervision from the next level of care will be problematic to sustain due to lack of funding. One strategy to overcome the shortage of staff for supervision as practised in Kenya could be to train public health nurses under routine supervision to include mental health activities in their itinerary (Bartlett et al., 2011). Formal community mental health support programs are still rare partly due to scarce resources; hence integrating mental health into primary care is crucial for population access to mental health care (Bartlett et al., 2011; World Health Organization, 2010).

11.8.3 Collaboration between the GMHA and TFHs

The introduction of the MHA also reinforces a formal engagement and collaboration between the GMHA, clinical services and TFHs in providing mental health services. The GMHA has commenced educating TFHs on aspects of their practice that conflict with the MHA and violate patients' rights. Notably, evidence from this Thesis that suggests some practices such as removing chains and legally freeing people confined into traditional and prayer camps were ongoing. This move forms part of the national conversation around the governance of TFHs.

11.9 The importance of the LHPS framework for policy implementation

Data from this Thesis identifies a lack of consideration of implementation strategies and methods for bridging the policy to practice gap that has characterised Ghana's past and present mental health policies.

This Thesis postulates that the LHPS framework could be used as a strategy to engage a diversity of stakeholders working with researchers, policymakers, and patient populations to facilitate the implementation of the MHA through the four components of the LHPS. In this

case, the MHA should be studied in partnership with the relevant policy related stakeholders from top-down and bottom-up. The relevant stakeholders should include patients or service users, healthcare providers, policymakers, and cross sector partners, including GHS, MoH, Social Welfare, NHIS and District Assemblies. Speedy and effective implementation of the MHA will require the aggregation of separate actions and the involvement of stakeholders. The LHPS framework will help in the identification of relevant stakeholders to communicate clear implementation objectives, ensure availability of resources, identify key policy implementers, identify and manage potential conflicts and opportunities for cooperation, and sustain policy changes over time (Oh et al., 2021). Multiple stakeholder engagement is vital because of the role of multiple actors in policy implementation.

For instance, while some studies have shown that a sample of policymakers working on health-related policies would typically rely on data and statistics as evidence (Dodson et al., 2015), other studies have grouped policymakers based on characteristics that may have implications for policy implementation (Purtle et al., 2017). One of the previous studies reported that policymakers concerned about budget impact are also sceptical of behavioural health treatment effectiveness (Purtle et al., 2018). Hence the need for multilevel stakeholder collaboration for the implementation of the MHA.

On the other hand patients are primarily concerned with access to primary healthcare services, patient participation in medical decisions, and partnering with their healthcare providers to make important decisions (Boivin et al., 2014), which is important for service improvement. Implementation Science as a field has emphasised the significance of stakeholder engagement for accelerating implementation efforts and increasing the likelihood that data are useful, scalable, and sustainable in real-world settings (Ramanadhan et al., 2018). Partnership with relevant stakeholders assist the LHPS to capture ongoing policy impact and implementation strategies over time, working to decrease the time lag from policy enactment to implementation, resulting in health outcomes (Oh et al., 2021).

The design and implementation of the MHA failed to acknowledge or engage the complex multi-level stakeholder groups resulting in poor policy advocacy and lack of interconnectedness of pertinent social systems. This gap has created significant challenges to post-implementation evaluation through failure to communicate the complex system changes across multilevel stakeholder groups. This Thesis demonstrates some stakeholders are not aware of their responsibilities under the MHA toward the provision of mental health services. The LHPS acknowledges the importance of multi-level stakeholder engagement and advocacy that will mainstream mental health services and could be adopted as an

implementation strategy by raising awareness of the MHA and the need for its full-scale implementation.

Data is critical for any policy implementation. Data measurement should include the ability to collect dynamic data and to enhance external validity. Mixed methods approaches may offer the ability to examine multilevel influences. Ensuring data collection through pulling metrics from the intersection of public administration, institutional and individual behaviour, implementation science, and political science may facilitate the measurement of important indicators, continuously monitoring policy change that will affect the process and impact of policy implementation. The iterative and systems approach in the LHPS model requires the measurement of both cross-sectional and longitudinal data. The MHA failed to incorporate research and continuous progress data collection as part of the implementation strategies. The lack of dynamic data and multi-sector metrics to guide the MHA implementation and feedback into the system, makes it difficult to identify both the determinants and impact of the policy implementation. The LHPS model advocates that data capture to be embedded in the implementation process to monitor if the MHA is achieving its desired impact on health, specifically tracking the impact of the third element of an LHPS, implementation strategies.

These implementation strategies should be relied upon to ensure the uptake and sustainability of the policies. They would be an integral part of studying the policy itself to measure whether the implementation strategies are effective and accounting for barriers and enablers for policy implementation. The LHPS model is developed to be iterative, collecting implementation data to support rapid-cycle testing of policy implementation for translation of outcomes consistent with the policy's intended goals (Oh et al., 2021).

The LHPS model is a departure from traditional policy evaluation frameworks because it emphasises implementation outcomes that are communicated back into the system for evaluation and improvement, facilitating the dissemination of the knowledge learned to stakeholders for use in future policymaking systems.

The model could be adopted and utilised in other developing African countries to accelerate the effective and efficient implementation of mental health policies. Its clear iterative components highlight a continuous stakeholder engagement, data collection and monitoring and the identification of resources for implementation. The advantage of using the LHPS is that it facilitates the examination of the intersection between health policy and implementation science, with policy playing specific roles including describing the context in which health interventions strategies are implemented to improve population health.

11.10 Contributions of this study to the field

Several studies, particularly in sub-Saharan Africa, have explored the poor implementation of mental health policies (Awenva et al., 2010; Drew et al., 2013; Flisher et al., 2007; Lund, Mental, et al., 2010). The difficulties in implementing these policies continue to be attributed to a lack of political commitment and leadership to provide resources for implementation (Doku et al., 2012). However, a number of these previous studies have not investigated the in-depth reasons for the lack of political commitment and leadership to prioritise mental healthcare by providing adequate resources for implementation. Findings in this Thesis suggest that there are limited data on the economic burden of mental illness, hence no justification for past and present Governments to invest resources in mental healthcare. Unlike other countries where data on the impact of mental illness on the economy has been reported (Chong et al., 2016; Cloutier et al., 2016; Trautmann et al., 2016; Vigo et al., 2016), there is limited data in Ghana and other sub-Saharan African countries (Addo, Agyemang, et al., 2018; Addo et al., 2013; Opoku-Boateng et al., 2017). Moreover, most studies in Africa, particularly Ghana, do not investigate the enabling factors that could influence key stakeholders, especially political leadership, to prioritise mental health service provision. The Thesis has provided new evidence from mental health key stakeholders' perspectives on specific barriers responsible for the delay in implementing the MHA. With a rural focus, this Thesis has assessed that disability in people with severe mental illness could be attributed to mental illness. Specifically, this research is the first to assess the knowledge of mental health service users about the introduction of the MHA and its impact on their mental healthcare.

11.11 Future research

This Thesis explored the barriers and enablers for implementing the MHA introduced in May 2012 to transform mental healthcare in Ghana. Over the period, the MHA implementation has been slow, even though some significant achievements have been made to improve mental health service provision. Based on the current findings, some suggestions for future research are provided, as follows:

1. Mental health epidemiological data are needed to support calls for the central Government to invest resources in mental healthcare. Research Institutions such as the universities and the research centres of the Research Development Division of the MoH and think tanks should be empowered to provide the evidence for health system changes. This will provide information about the relationship between health problems seen as high mortality driven and those such as mental health that are high disability. In this research, participants discussed the need for health researchers to conduct

mental health research and provide data to justify Government's investment of resources into implementing the MHA.

2. Future research should employ a quantitative approach to generate additional data on the burden of mental health in Ghana, as current statistics are always based on estimates from reports. The findings also point future research towards exploring the burden of mental illness and how it potentially affects economic development. The state may provide resources for mental healthcare based on available compelling data that describes the consequences of not addressing mental health issues in the country.
3. Research on mental health policy in Ghana should be directed towards evaluating the impact of these policies on service user satisfaction and quality of life.
4. Existing evidence has not assessed the human rights institutions' preparedness and capacity to protect the rights of people living with mental disorders. Future research should aim to assess the capacities of the Judicial Services, CHRAJ, Police Services, and the Department of SWCD to address human rights violation and protection.
5. This Thesis provides a strong justification for a collaboration between conventional mental health providers and TFHs to provide services for people living with mental illness. However, the nature of the proposed collaboration has not been investigated and established. Further research should focus on sustainable strategies that allow for development of a Ghanaian pluralistic and biomedical model of mental healthcare without violating the fundamental beliefs of either practice

11.12 Policy and practice implications

The Thesis findings provide evidence for practical and achievable strategies for the speedy implementation of the MHA in Ghana. The main policy priority is to institute the mental health levy, legally creating the necessary financial support for implementing the MHA. Adequate resourcing will propel the transformation of mental health reforms by providing the required logistics, including human resources, to deliver effective and efficient mental healthcare in community settings.

11.12.1 Implications for Government

Central Government leadership and intersectoral collaboration between the various Government departments and relevant NGOs including TFHs is paramount to the successful implementation of the MHA. This Thesis established baseline data and generated a blueprint for future measurement of progress in implementing the MHA. Moreover, the study indirectly

increased intersectoral stakeholder awareness of the legislative framework governing mental healthcare in Ghana.

11.12.2 Implications for healthcare providers

For healthcare professionals who seek to enhance mental healthcare, the Thesis established the need to identify an integrated care practice model for regulating and incorporating TFHs into a contemporary mental healthcare model. This Thesis has also identified strategies to make conventional mental healthcare attractive through improved mental health service provision.

11.12.3 Implications for District Assemblies

District Assemblies are responsible for ensuring that Government policy and legislative requirements are directly implemented at a local level. As a representative of central Government at the communities, it was strongly argued throughout this Thesis for District Assemblies to invest DACF money constructing accommodation for people with mental illness who are homeless and in need of stable accommodation to assist their recovery. This step will facilitate closer contact with this vulnerable group with the aim to providing them with more supportive services. The implication is that the Assemblies must make budgetary allocation for mental health activities including promotion and advocacy.

11.12.4 Implications for communities and families

At the communities, families, and mental health service users' level, this Thesis offers an insight into crucial variables for reinforcing human rights surveillance and protection through active community participation to increase awareness of mental health issues. It justifies advocacy to promote mental healthcare at the community level, a key focus of the new mental health policy. The partial integration of mental health into primary care has had a direct effect on the reduction of stigma and discrimination in the communities.

11.12.5 Implications for sub-Saharan African countries

African countries have cultural variations depending on the colonial history, but many similarities exist in most countries regarding dualism or pluralism in religious faith. This Thesis will be particularly relevant for other sub-Saharan African countries that also utilise the services of TFHs for mental health delivery and can be used for public engagement, advocacy,

and capacity building in mental health. Currently, many sub-Saharan African countries still do not have established mental health policies to improve and maintain the mental health and wellbeing of citizens or to protect their human rights. Findings from this Thesis will hopefully provide an insight into the barriers and enablers that can impede implementation. It adds to the body of knowledge in this area within the African context.

11.13 Strengths and limitations

The strength of this Thesis lies in its design, and the mixed-method approach. Using this simultaneous mixed-method design made it possible to explore broader views of mental health key stakeholders, including service users, and documented the barriers inhibiting the implementation of the MHA. This approach made it possible to triangulate ideas from key stakeholders that were either promoting or indirectly impeding implementation of the MHA. The approach provided more detailed information to elucidate the complex issues surrounding mental health policy implementation challenges in a low-income setting such as Ghana. The study has some limitations that need to be acknowledged:

1. By the design, data was self-reported and therefore subject to selective retention or exaggeration (Althubaiti, 2016). It could be argued that self-reported data cannot be independently confirmed, nevertheless, attempts were made to reduce bias through interviewing different stakeholders on the same subject matter allowing for triangulation of the data.
2. The observation study was limited to two prayer camps over a relatively short duration – one extended day in each of the two study locations. Given this short duration, it was possible that particular behaviours or practices could have been missed. Nevertheless, participants were observed in their natural settings and were seen engaging in their regular daily routines. The depth of the data collected has enabled the building up of daily descriptions of practices in the prayer camps.
3. There was little opportunity to consider the extent to which the needs of children accompanying parents with mental illness to the prayer camps were being addressed due to the short duration of the observation. It was noted that there were no schools or facilities for social gatherings in the prayer camps. The developmental and safety needs and human rights concerns of children residents in the prayer centres were largely overlooked. This is an important area that should be considered in future research.

4. The quantitative study had comparatively small sample size (see section 4.2), and due to the small number of participants in some of the diagnostic groupings, the differences based on diagnosis were unfortunately not assessed.
5. By the nature of the qualitative research design, the researcher's presence may distort the findings during data collection. However, the combination of qualitative and quantitative approaches provided a much more complete picture of barriers and enablers for implementing the MHA.

11.14 Recommendations

Based on the findings from stakeholders' interviews on the barriers and enablers for implementing the MHA in Ghana, several recommendations for policy and clinical practices are made:

Funding	1. Government should establish a quarantined recurrent national mental health budget 2. Department of Finance should establish a recurrent mental health levy 3. Government should legislate to cover for mental-health related medications to be subsidised through the NHIS 4. Government should legislate for people with enduring mental health needs to qualify for social support through the LEAP 5. Minister of Local Government and Rural Development (MLGRD) should identify and direct a recurrent percentage of the District Assemblies Common Fund (DACF) to be quarantined by the Metropolitan, Municipal and District Assemblies to support emergency accommodation and reintegration of people in their districts that are homeless secondary to mental illness and other psychological disorders 6. GMHA should receive recurrent funding to train and develop a mental health workforce to work within an integrated primary care model 7. Government through the Mental Health Authority should fund a national mental health promotion and prevention strategy

	directed at improving mental health literacy at the community as well as improving the physical health of mental health consumers and their carers
Workforce/training & infrastructure	1. GHMA should develop a five-year mental health workforce strategic plan supporting the Government's integrated mental health reform agenda 2. GMHA should deliver a broad range of courses, programmes and education opportunities to respond to the training needs of relevant staff including mental health workforce, non-specialist mental health professionals, private health providers, relevant NGOs, District Chiefs/Nanas and media 3. GMHA should develop a national mental health literacy program to increase awareness of mental health issues, aid access to services and to reduce stigma and discrimination 4. GMHA should develop and oversee full operationalisation of the regional mental health sub-committees, and regional mental health tribunals 5. Government through the Ghana Statistical Services (GSS) and in partnership with the GMHA should consider the development of a National Mental Health Survey to estimate the prevalence of mental disability and as an adjunct to future service development
TFHs/Indigenous practitioners	1. GMHA should develop governance protocols to regulate the practice of TFHs and other Indigenous practitioners 2. GMHA should work in partnership with TFHs and other Indigenous practitioners to develop their role within an integrated primary care model
Service users/ carers	1. The GMHA should facilitate the formation or strengthening of professional organisations and advocacy/watchdog groups such as user and carer Self-Help Groups through

	development grants that may be either donor, Government, or public-private funded
Media publicity	1. The GHMA should train the media and establish media liaisons in key positions to report important mental health developments

11.15 Conclusions

The introduction of the MHA in 2012 to promote and improve mental health service provision has been recognised locally and internationally as an excellent step for transforming mental healthcare in Ghana. Over the period, there have been some major achievements in mental health service provision attributable to the introduction of the MHA. Some of these notable achievements include establishing the GMHA, the appointment of RMHCs entrusted with the mandate to coordinate mental health services in the various administrative regions, and other mental health personnel that invariably increased access to mental health services. The MHA also formerly recognised TFHs as informal community mental healthcare providers, imposing a certain level of responsibility on TFHs to ensure that patients are treated with dignity and consonance with the MHA statutory requirements. Also, the GMHA has another level of responsibility of regulating and monitoring the practices of TFHs to ensure patient's rights are respected and protected as stipulated by the MHA. In addition, the MHA has resulted in a systematic reduction in the use of chains and flogging of people with mental illness to drive out evil spirits.

The study has also established that the MHA's introduction does not guarantee sufficient and adequate mental health service provision for people living with mental disorders in Ghana. An examination of the main reason for the slow implementation of the MHA exposed a lack of political commitment and leadership to invest adequate resources in mental healthcare. The state has failed to establish a dedicated and sustainable funding source for mental healthcare regardless of the MHA statutory provision, which mandates establishing a separate funding source. The low allocation of resources for mental healthcare results in poor mental health service provision, which affects the implementation of the MHA. Also, there was low knowledge penetration of the MHA among key stakeholders, especially mental health service users who are the primary beneficiaries of the mental health policy. This low awareness of the MHA was secondary to the lack of implementation of the MHA.

Integrating mental health in primary healthcare and collaboration between various healthcare providers could be an excellent strategy in harnessing and maximising the human and material

resources and, more significantly, destigmatising mental illness. Government commitment and investment in mental healthcare will be a significant factor in facilitating the MHA implementation to ensure the desired improvement of Ghana's mental healthcare delivery.

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APPENDIX A: Questionnaire for participants with severe mental disorders

Appendix IV	University of Newcastle, Australia Kintampo Health Research Centre, Ghana Case Register of Severe Mental Disorders **Mental Health Act 846 Implementation Study** Version 2; 22/01/19	

This form will be completed for people with severe mental disorders. We are seeking your consent to participate in this study to assess the barriers and enablers for the implementation of the 2012 Mental Health Act 846. Participation is completely voluntary and your data is anonymous and confidential.

First, we'd like to ask few questions about you

1. What is the name of your community?	
2. What is your compound number?	
3. What is your permanent individual identity number?	
4. What is your gender?	**1** = Male **2** = Female
5. What is your date of birth (***DD/MM/YY***)	
6. How old are you (Age)?	
7. Highest educational attainment	**1** = None **2** = Primary **3** = JHS/Middle School **4** = Secondary **5** = Tertiary
8. What is your relationship status?	**1** = Single **2** = Married **3** = Living together **4** = Widowed/separated/Divorced
9. What is your religious orientation?	**1** = None **2** = Christian **3** = Islam **4** = Traditional African **5** = Other (specified)
10. Which ethnic group do you belong to?	**1** = Akan **2** = Northern descent **3** = Ga/Ewe 4 = Mo 5 = Fulani **6** = Other (specified)
11. What is your employment status?	**1** = Employed **2** = Unemployed

Diagnosis and cost of treatment

12. Is index case available to work?	**1** = Yes **2** = No
13. Date of onset of illness (***DD/MM/YY***)	
14. Has index case ever sought treatment?	1 = Yes 2 = No
15. ICD 10/DSM-V Diagnosis	
16. Does index case have family history of mental illness?	1 = Yes 2 = No
17. If yes above, describe family member	**1** = Parent **2** = Sibling **3** = Grandparent **4** = Other (specified) **5** = Not Applicable
18. Has index case ever sought traditional treatment?	**1** = Yes **2** = No
19. Is index case the owner of current residence?	**1** = Yes **2** = No **3** = Joint ownership
20. Current Psychiatric Status of case	**1** = Not receiving formal psychiatric treatment **2** = Inpatient psychiatric care **3** = Outpatient/community psychiatric care **4** = Receiving traditional healing **5** = Receiving both traditional & orthodox treatments **6** = Receiving healing from religious camp/pastor/Mallam **7**= Multiple Treatment source (specified)
21. Date last seen by health worker ***(DD/MM/YY)***	

Support from Stakeholders in the last 12 months

22. In the last 12 months, have you accessed any help from any agency for your condition?	1. Yes	2. No	3. DK
23. Support from the District Assembly / Local council	1. Yes	2. No	3. DK

24. Mental Health user advocacy groups	1. Yes	2. No	3. DK
25. Index case is able to access support from Social Welfare	1. Yes	2. No	3. DK
26. Community rehabilitation services available	1. Yes	2. No	3. DK
27. Index case is able to access Legal services	1. Yes	2. No	3. DK
28. The index case is registered onto the National Health Insurance Scheme (NHIS)?	1. Yes	2. No	3. DK
29. The index case is currently an active member of the NHIS?	1. Yes	2. No	3. DK
30. The registration onto the NHIS was done for the index case free of charges?	1. Yes	2. No	3. DK
31. Give reason if the index case is not registered onto the NHIS			
32. The index case is registered for the Livelihood Empowerment Against Poverty (LEAP) programme by the Social Welfare Department	1. Yes	2. No	3. DK
33. Give reason if the index case is not registered onto the LEAP programme			

Knowledge and Impact of the 2012 Mental Health Act 846

34. Have you heard about the 2012 Mental Health Act 846?	1. Yes	2. No	3. DK
35. The MHA is primarily aim at providing mental health care for people with mental illness	1. Yes	2. No	3. DK
36. Are you aware of your rights provided by the MHA?	1. Yes	2. No	3. DK
37. Has it help in creating access to mental health services?	1. Yes	2. No	3. DK
38. It brought about reduction in treatment gap	1. Yes	2. No	3. DK
39. It brought about availability of psychotropic medicine	1. Yes	2. No	3. DK
40. Index case know where to report abuse / violation of his/her human rights	1. Yes	2. No	3. DK
41. Are you able to complain to the appropriate authority about abuse of your rights in accessing treatment for your condition?	1. Yes	2. No	3. DK
42. Will you say the introduction of the MHA has lessen your financial burden?	1. Yes	2. No	3. DK
43. Clearing the streets of people with mental illness and connecting them to treatment	1. Yes	2. No	3. DK
44. Generally, has the MHA 846 bring about improved mental health care from your perspective?	1. Yes	2. No	3. DK

Researcher Code_____

Thank the Respondent for his/her time

Complaints about this research

The Ethics Committees of both the Kintampo Health Research Centre and the University of Newcastle reviewed and approved this research. These committees are responsible for ensuring that participants rights are protected. If you have questions or issues about your rights as a research participant, kindly contact the Administrator of Kintampo Health Research Centre Institutional Ethics Committee, by telephone at +233 504270501, email fred.kanyoke@kintampo-hrc.org or the Human Research Ethics Officer, Research Services, NIER Precinct, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone +61 49216333, email human-ethics@newcastle.edu.au.

APPENDIX B: WHODAS-12

Appendix V

University of Newcastle, Australia
Kintampo Health Research Centre, Ghana
Mental Health Act 846 Implementation Study
World Health Organization Disability Assessment Schedule (WHODAS II)

We are seeking your consent to participate in this study to assess the barriers and enablers for the implementation of the 2012 Mental Health Act 846. This interview has been developed by the World Health Organization to better **understand the difficulties people may have due to their health conditions**. The information that you provide in this interview is confidential and will be used only for research.

Section 1. Demographic and Background Information

1. What is the name of your community?	
2. Living Situation at time of Interview	**1** = Independent in Community **2** = Assisted Living **3** = Hospitalized
3. What is your compound number?	
4. Respondent ID	
5. Interview Date (DD/MM/YY)	
6. Record Sex as Observed	1 = Male 2 = Female
7. What is your date of birth (DD/MM/YY)	
8. How old are you now (Age)?	
9. Number of years in spend studying in school	
10. Highest educational attainment	**1** = None **2** = Primary **3** = JHS/Middle School **4** = Secondary **5** = Tertiary
11. What is your current relationship status?	**1** = Single **2** = Married **3** = Living together **4** = Widowed/separated/Divorced
12. What is your employment status?	**1** = Employed **2** = Unemployed

Section 2. Core Questions

13. How do you rate your overall health in the past 30 days?	**1** = Very good **2** = Good **3** = Moderate **4** = Bad **5** = Very Bad

In the last 30 days how much difficulty did you have in:

	None	Mild	Moderate	Severe	Extreme / Cannot Do
S1. Standing for long periods such as 30 minutes?	1	2	3	4	5
S2. Taking care of your household responsibilities?	1	2	3	4	5
S3. Learning a new task, for example, learning how to get to a new place?	1	2	3	4	5
S4. How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5
S5. How much have you been emotionally affected by your health problems?	1	2	3	4	5
S6. Concentrating on doing something for ten minutes?	1	2	3	4	5
S7. Walking a long distance such as a kilometre [or equivalent]?	1	2	3	4	5
S8. Washing your whole body?	1	2	3	4	5
S9. Getting dressed?	1	2	3	4	5
S10. Dealing with people you do not know?	1	2	3	4	5
S11. Maintaining a friendship?	1	2	3	4	5
S12. Your day to day work?	1	2	3	4	5

Section 3. Overall Rating

R1. Overall, how much did these difficulties interfere with your life? Read choices to respondent.	**1** = None **2** = Mild **3** = Moderate **4** = Severe **5** = Extreme / Cannot Do
R2. Overall, in the past 30 days, how many days were these difficulties present?	☐☐
R3. In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	☐☐
R4. In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	☐☐

End of WHODAS II form, thank you for participating

Complaints about this research

The Ethics Committees of both the Kintampo Health Research Centre and the University of Newcastle reviewed and approved this research. These committees are responsible for ensuring that participants rights are protected. If you have questions or issues about your rights as a research participant, kindly contact the Administrator of Kintampo Health Research Centre Institutional Ethics Committee, by telephone at +233 504270501, email fred.kanyoke@kintampo-hrc.org or the Human Research Ethics Officer, Research Services, NIER Precinct, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone +61 49216333, email human-ethics@newcastle.edu.au.

APPENDIX C Interview schedule with mental health key stakeholders

Appendix I
Faculty of Health and Medicine
School of Medicine and Public Health

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Document Version 2; dated 22/01/19

Interview Schedule with Mental Health Key Stakeholders

Title of Project: Implementation of the Mental Health Act in Ghana: A study of potential barriers and enablers using a mixed-method approach

1. **Introduction**
   a. Thank you for agreeing to participate in this research interview
   b. Please describe your role and background?
   c. How long have you been working in this institution / capacity?
2. **Experience of the Mental Health Act 846 of 2012**

From your perspective:

   a. Do you have a responsibility for ensuring that the MHA 846 is effectively implemented? Please discuss and provide example.
   b. What is the level of understanding amongst relevant colleagues in your institution of the legislative requirements of the MHA 846? Please discuss and provide examples.
   c. What is the level of progress achieved with overall implementation of MHA 846? Discuss & provide examples.
   d. What do you see as the major barriers in your region to implementation of the MHA 846? Discuss & provide examples.
   e. What strategies would further enable progress with your region to expedite implementation of the MHA 846? Please discuss and provide examples.

3. **Impact of the MHA on livelihood of People with Mental Disorders (PMDs)**

From your perspective:

   a. To what degree do you think PMDs are aware of the existence of the MHA 846? Discuss & provide examples.
   b. Has adequate education of rights and responsibilities under the MHA 846 been provided to the public? Please discuss and provide examples.
   c. Has the introduction of the MHA 846 resulted in access to affordable mental health care or increased availability of community-based rehabilitation services? Please discuss and provide examples.
   d. Has the introduction of the MHA 846 provided an accessible mechanism for PMDs to complain about abuse to the appropriate authority for redress? Please discuss and provide examples.
   e. Has the introduction of the MHA 846 contributed to a reduction in stigma and discrimination against PMDs? Please discuss and provide examples.
   f. Has the introduction of the MHA 846 provided access to care within the requirements of a least restrictive treatment environment? Please discuss and provide examples.

4. **Political and socio-cultural factors**

From your perspective;

   a. How committed is the state in ensuring mental health care is given the needed attention? Please discuss. (Policies & programmes, commitment of resources for mental health care, training, etc.)
   b. What are major problems faced by the main psychiatric hospitals in mental health care? (timely release of feeding grants, other relevant mental health services? Please discuss.
   c. To what degree do cultural belief systems and mental health literacy play a role in implementation of the MHA 846? Please discuss and provided examples.

5. **Significant Partners**

From your opinion;

   a. What is the role of Non-Government Organisations in the implementation of the MHA 846 and to what degree are they involved in the implementation? Please discus
   b. What is your estimation of the community responsiveness in the implementation of the MHA in the Kintampo Municipality of Ghana? Please discuss.
   c. What role can the community opinion leaders play to bring about mental health reforms in their communities? (e.g. Chiefs, Queen mothers, Assembly representative). Please discuss.
   d. What is the role of the Council of Persons with Disability toward the implementation of the MHA 846? Explain.
   e. What has been the role of users/caregivers in the implementation of the MHA 846 and to what degree have they been consulted and involved? Please discuss.

6. **Traditional and Faith-based practitioners (TFP)**

From your perspective:

a. Are TFP relevant in mental health care in the new mental health care reform in Ghana? Please discuss & provide examples.
b. What role can TFP play within the new model of care mandated under the MHA 846? Please discuss
c. What can be done to prevent human rights violations by TFP? Please discuss.

7. Legal Framework

In your opinion:

a. What is preventing the passage of the Legislative Instrument to create consistent funding for mental health care and what can be done to expedite the process? Please discuss.
b. What is the role of the Judiciary in the implementation of the MHA 846 in Ghana? Please discuss.
c. What is the role of the Commission for Human Rights and Administrative Justice in implementing the MHA 846? Please discuss.

8. Health System Organisation

a. In your opinion how should the Mental Health Authority position its self with the Ghana Health Service/Ministry of Health for maximum operational benefit? Please discuss.

9. Information Systems

From your experience:

a. Is there a database for mental health care in the Ghana and how is this being used to support the implementation of the MHA 846? Please discuss?
b. How are information systems being used to consult with service users, providers and to promote care within a least restrictive environment? Please discuss.

10. Social Protection

From your knowledge:

a. Are PMDs registered with the Social Welfare Department for the Livelihood Empowerment Against Poverty entitlement? Please discuss.
b. Are PMDs registered for National Health Insurance Scheme? Please discuss.
c. Are there other social protection measures put in place under the MHA 846 to support PMDs? Please discuss

11. Progress of the MHA 846 implementation

From your experience:

a. What does your role entail under the MHA 846?
b. What has been the progress of the introduction of the MHA 846 so far? (Human, Financial, Capital resources in place). Please discuss and provide examples.
c. What has been the priority areas for implementation of the MHA?
d. Has the following provision in the MHA 846 been established?
    I. Establishment of the Ghana Mental Health Authority (GMHA)
    II. Procedure for voluntary and involuntary treatment for PMDs
    III. Establishment of a Mental Health Review Tribunals
    IV. Establishment of Regional Visiting Committees
    V. Establishment of a Mental Health Fund
    VI. Sanctions for the offences of neglect or discrimination
    VII. Procedures for the protection of the rights of vulnerable groups

12. Challenges with Implementing the MHA 846

From your experience:

a. Over the past 6 years, what have been the major barriers to implementation of the MHA 846? Please discuss and provide examples.
b. Can you identify enablers that would assist in further progressing and fast-tracking implementation of the MHA 846 in Ghana? Please discuss.

13. Summary and debriefing

a. Do you have anything else to add to our discussion today regarding the MHA 846 implementation?

APPENDIX D Interview schedule with TFHs

Appendix II
Faculty of Health and Medicine
School of Public Health and Medicine **Document Version 2; dated 22/01/19**

Interview Schedule with Traditional and Faith-based Practitioners
Title of Project: Implementation of the Mental Health Act in Ghana: A study of potential barriers and enablers using a mixed-method approach

1. **Introduction**
   a. Thank you for agreeing to participate in this research interview
   b. Please describe your role and background?
   c. How long have you been working in this institution / capacity?
2. **Role of Traditional and Faith-based practitioners (TFP)**
   From your perspective:
   a. Why do people seek your services? Please discuss.
   b. How are people referred to your services? Please explain and provide examples.
   c. What type of problems do people have that present to your services for care? Please discuss
   d. What treatments do you provide? Please explain and provide examples.
   e. Averagely how long do people stay in your care? Please discuss
   f. What types of patients/problems respond best to your care? Please discuss and provide examples.
3. **Experience of the Mental Health Act 846 of 2012**
   In your opinion:
   a. Are TFP aware of the existence of the 2012 MHA 846 and its provision? Please discuss and provide examples.
   b. Have you been consulted on your role and required changes in your practice to comply with the legislative requirements under the 2012 Mental Health Act 846? Please discuss.
   c. Is there a relevant role for TFPs under the Mental Health Act? Please discuss.
   d. How can your services and the services of other TFPs be integrated into the new mental health care reform? Please discuss.
   e. What is the level of understanding amongst your TFP colleagues about the legislative requirements of the MHA 846? Please discuss and provide examples.
   f. What is the level of progress achieved with overall implementation of the MHA 846? Please discuss
   g. What strategies would further enable progress with your region to expedite implementation of the MHA 846? Please discuss and provide examples.
   h. What can be done to protect against human rights violations by TFPs and other health care providers? Please discuss.
4. **Impact of the MHA on livelihood of People with Mental Disorders (PMDs)**
   From your perspective:
   g. To what degree do you think PMDs and those in your care are aware of the existence of the MHA 846 and their rights and responsibilities under the Act? Please discuss
   h. How are people in your care provided with information on their rights and responsibilities under the MHA 846.? Please explain and provide examples.
   i. Has the introduction of the MHA 846 increased availability of community-based rehabilitation services? Please discuss and provide examples.
   j. What has been the role of users/caregivers in the implementation of the MHA 846 and to what degree have they been consulted and involved? Please discuss.
   k. What do you see as the major barriers in implementation of the MHA 846? Please discuss.
   l. Can you identify enablers that would assist in further progressing and fast-tracking implementation of the MHA 846 in Ghana? Please discuss.
5. **Summary and debriefing**
   b. Do you have anything else to add to our discussion today regarding the MHA 846 implementation?

APPENDIX E Interview schedule with mental health users and carers

Appendix III
Faculty of Health and Medicine
School of Public Health and Medicine

Document Version 2; dated 22/01/19

Interview Schedule with Mental Health Users and Carers

Title of Project: Implementation of the Mental Health Act in Ghana: A study of potential barriers and enablers using a mixed-method approach

1. **Introduction**
   a. Thank you for agreeing to participate in this research interview
   b. Please describe your background briefly?
   c. Do you suffer from a mental health disorder?
   d. Do you receive treatment for your mental disorder? Please explain and provide examples
   e. Do you attend a traditional or faith-based practitioner? Please discuss
   f. Are you a carer for someone who suffers from a mental disorder?
   g. How long have you been a carer? Please discuss
   h. Does the person that you provide care for attend a traditional or faith-based practitioner? Please discuss

2. **Experience of the Mental Health Act 846 of 2012**
   From your perspective:
   a. To what degree do you think people with mental disorders and carers are aware of the existence of the MHA 846? Please discuss.
   b. To what degree do you think that people with mental disorders and carers understand their rights and responsibilities under the MHA 846? Please discuss.
   c. What has been the role of users/caregivers in the implementation of the MHA 846 and to what degree have they been consulted and involved? Please discuss.
   d. Has the introduction of the MHA 846 increased availability of community-based rehabilitation services? Please discuss and provide examples.
   e. How prepared are the institutions responsible for the organisation and oversight of mental health care in Ghana for the implementation of the MHA 846 of 2012? Please discuss
   f. What is the role of traditional & faith-based practitioners (TFP) in the implementation of the MHA 846?
   g. What can be done to prevent human rights violations by TFH and other health care providers? Discuss.
   h. How can the system integrate TFP into the new mental health care reform? Please discuss.
   i. How is the community receiving the introduction of the MHA 846 in the Kintampo area of Ghana?
   j. What is the level of progress achieved with overall implementation of the MHA 846?
   k. What strategies would further enable progress with your region to expedite implementation of the MHA 846? Please discuss and provide examples.
   l. What do you see as the major barriers in implementation of the MHA 846? Please discuss.
   m. Can you identify enablers that would assist in further progressing and fast-tracking implementation of the MHA 846? Please discuss.
   n. What is the overall impact of the of the introduction of the MHA 846 in your life? Discuss

3. **Summary and debriefing**
   a. Do you have anything else to add to our discussion today regarding the MHA 846 implementation?

APPENDIX F Ethics approvals

Kintampo Health Research Centre (KHRC) Institutional Ethics Committee (IEC)
P.O Box 200
Kintampo, B/A
Ghana, West Africa

Tel: +233(3520)92037/+233504270501
E-mail: ethics@kintampo-hrc.org
fred.kanyoke@kintampo-hrc.org

FULL ETHICAL APPROVAL CERTIFICATE

Kenneth Ayuurebobi Ae-Ngibise
Kintampo Health Research Centre
Box 200
Kintampo, B/A
Ghana, West Africa

Date: 26th November, 2018

Study ID: KHRCIEC/2018-25

Title of study: Implementation of the Mental Health Act in Ghana: Astudy of potential barriers and enablers using a mixed-method approach.

Principal Investigator: Kenneth Ayuurebobi Ae-Ngibise (PhD Candidate)

Supervisor(s): Prof. Michael Hazelton, A/Prof. Chris Kewley, Prof. David Perkins, Dr. Kwaku Poku Asante.

Type of Review: Full Board Review

Approval Date: 20th November, 2018

Expiration Date: 20th November, 2019

1. The Kintampo Health Research Centre Institutional Ethics Committee (IEC) is constituted and operates in conformance with requirements of 45 CFR 46, 21 CFR 50, 21 CFR 56 and section 3 of the International Council on Harmonization Guidelines, as well as all applicable regulatory, legal, and other ethical requirements governing human subject research in Ghana. The OHRP Federal Wide Assurance number for the committee is 00011103; the IRB registration number is 0004854.

2. The above study in title was reviewed by the IEC on 20th November, 2018 and given full ethical approval.

3. The following documents were reviewed and approved;
   - 3.1 Implementation of the Mental Health Act in Ghana: A study of potential barriers and enablers using a mixed-method approach. Version 1, Dated 26th October 2018
   - 3.2 Participant Information Statement (Stakeholder/Institutional), Version 1, dated 31/08/18
   - 3.3 Participant Information Statement (Mental Health User), Version 1, dated 31/08/18
   - 3.4 Participant Information Statement (Traditional and faith-based Healers), Version 1, dated 31/08/18
   - 3.5 Participant Information Statement (Primary Carer), Version 1, dated 31/08/18
   - 3.6 Consent form for the Research project. Version 1, dated 31/08/18
   - 3.7 Confidentiality Agreement. Version 1, dated 31/08/18

Study File number: 2018-25

Page 1 of 2

THE CHAIRMAN
KINTAMPO HEALTH RESEARCH CENTRE
INSTITUTIONAL ETHICS COMMITTEE.

Kintampo Health Research Centre (KHRC) Institutional Ethics Committee (IEC)

P.O Box 200
Kintampo, B/A
Ghana, West Africa

Tel: +233(3520)92037/+233504270501
E-mail: ethics@kintampo-hrc.org
fred.kanyoke@kintampo-hrc.org

3.8 Data Collection tools. Version 1, dated 31/08/18
3.9 Study Budget
3.10 Curriculum vitae of study Investigators.

4. During study implementation, the IEC must be informed within 72 hours by the principal investigator (PI) of learning of any (a) unexpected, serious, study related adverse events; (b) disclosed adverse events, or (c) unanticipated problems with the study which may pose risk to study participants or others (if applicable).

5. All safety monitory reports, including DSMB summaries and reports, must be submitted to the IEC as soon as they become available to PI(s) (if applicable).

6. Changes or modifications to this research activity must be submitted and approved by the IEC before they are implemented.

7. PI(s) would be required to submit application for renewal of this approval certificate (if the study lasts for more than 12 months) plus a progress report.

8. PI(s) is required to notify the IEC of study completion (end of data collection/last follow-up) or early termination of the research project.

9. Submit final report of the study three months after approval certificate expires (study closure).

10. Before conduct of the study, submit original/final copy of your informed consent forms for **authentication stamp** before making photocopies for your consent process.

11. Regulated study records, including IEC approvals and signed consent forms, must be securely maintained by PI(s) and available for audits for three years after the study is closed with the IEC.

Sincerely,

THE CHAIRMAN
KINTAMPO HEALTH RESEARCH CENTRE
INSTITUTIONAL ETHICS COMMITTEE.

.....
Dr. Damien Punguyire
Chair
Institutional Ethics Committee
Kintampo Health Research Centre

Study File number: 2018-25

HUMAN RESEARCH ETHICS COMMITTEE

Notification of Expedited Approval

To Chief Investigator or Project Supervisor: **Professor Michael Hazelton**
Associate Professor Chris Kewley Professor David Perkins
Mr Kenneth Ae-Ngibise Dr Kwaku Asante
Implementation of the Mental Health Act in Ghana: A study of potential barriers and enablers using a mixed-method approach
Date: **03-May-2019**
Reference No: **H-2018-0424**
Date of Initial Approval: **03-May-2019**

Thank you for your **Response to Conditional Approval (minor amendments)** submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.
Your submission was considered under **Expedited** review by the Ethics Administrator.

We are pleased to advise that the decision on your submission is **Approved** effective **03-May-2019**.

In approving this protocol, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research, 2007, and the requirements within this University relating to human research.
Approval will remain valid subject to the submission, and satisfactory assessment, of annual progress reports. *If the approval of an External HREC has been "noted" the approval period is as determined by that HREC.*
The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal *Certificate of Approval* will be available upon request. Your approval number is **H-2018-0424**.

If the research requires the use of an Information Statement, ensure this number is inserted at the relevant point in the Complaints paragraph prior to distribution to potential participants You may then proceed with the research.

Conditions of Approval

This approval has been granted subject to you complying with the requirements for *Monitoring of Progress*, *Reporting of Adverse Events*, and *Variations to the Approved Protocol* as detailed below.

PLEASE NOTE:
In the case where the HREC has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the

University's HREC.

- ***Monitoring of Progress***

Other than above, the University is obliged to monitor the progress of research projects involving human participants to ensure that they are conducted according to the protocol as approved by the HREC. A progress report is required on an annual basis. Continuation of your HREC approval for this project is conditional upon receipt, and satisfactory assessment, of annual progress reports. You will be advised when a report is due.

- ***Reporting of Adverse Events***

1. It is the responsibility of the person **first named on this Approval Advice** to report adverse events.
2. Adverse events, however minor, must be recorded by the investigator as observed by the investigator or as volunteered by a participant in the research. Full details are to be documented, whether or not the investigator, or his/her deputies, consider the event to be related to the research substance or procedure.
3. Serious or unforeseen adverse events that occur during the research or within six (6) months of completion of the research, must be reported by the person first named on the Approval Advice to the (HREC) by way of the Adverse Event Report form (via RIMS at https://rims.newcastle.edu.au/login.asp) within 72 hours of the occurrence of the event or the investigator receiving advice of the event.
4. Serious adverse events are defined as:
   - Causing death, life threatening or serious disability.
   - Causing or prolonging hospitalisation.
   - Overdoses, cancers, congenital abnormalities, tissue damage, whether or not they are judged to be caused by the investigational agent or procedure.
   - Causing psycho-social and/or financial harm. This covers everything from perceived invasion of privacy, breach of confidentiality, or the diminution of social reputation, to the creation of psychological fears and trauma.
   - Any other event which might affect the continued ethical acceptability of the project.

5. Reports of adverse events must include:
   - Participant's study identification number;
   - date of birth;
   - date of entry into the study;
   - treatment arm (if applicable);
   - date of event;
   - details of event;
   - the investigator's opinion as to whether the event is related to the research procedures; and
   - action taken in response to the event.

6. Adverse events which do not fall within the definition of serious or unexpected, including those reported from other sites involved in the research, are to be reported in detail at the time of the annual progress report to the HREC.

- ***Variations to approved protocol***

If you wish to change, or deviate from, the approved protocol, you will need to submit an *Application for Variation to Approved Human Research* (via RIMS at https://rims.newcastle.edu.au/login.asp). Variations may include, but are not limited to, changes or additions to investigators, study design, study population, number of participants, methods of recruitment, or participant information/consent documentation. **Variations must be approved by the (HREC) before they are implemented** except when Registering an approval of a variation from an external HREC which has been designated the lead HREC, in which case you may proceed as soon as you receive an acknowledgement of your Registration.

Linkage of ethics approval to a new Grant

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.
Human Research Ethics Committee

For communications and enquiries:
Human Research Ethics Administration

Research & Innovation Services
Research Integrity Unit
The University of Newcastle
Callaghan NSW 2308
T +61 2 492 17894
Human-Ethics@newcastle.edu.au

RIMS website - https://RIMS.newcastle.edu.au/login.asp

Linked University of Newcastle administered funding:

Funding body	Funding project title	First named investigator	Grant Ref

APPENDIX G Permission to access mental health psychiatric care register

Our Core Values
1. People-Centred
2. Professionalism
3. Team Work
4. Innovation
5 Discipline
6. Integrity

My Ref No. MHD/KN/ P
Your Ref No.

Municipal Health Directorate.
Ghana Health Services
P. O. Box 2
Kintampo B/A
Tele/Fax :03520 -26019

15th January, 2019

Dear Sir/Madam,

Permission to access Mental Health Psychiatric Care Register for Student Research

I write on behalf of the Kintampo Municipal Health Management Team to express my support for the conduct of a student research proposal titled: "Implementation of the Mental Health Act in Ghana: A study of Potential Barriers and Enablers using a Mixed Method Approach". The student research is led by Kenneth Ae-Ngibise who is a staff of the Kintampo Health Research Centre and currently enrolled in PhD (Psychiatry) at the University of Newcastle's School of Medicine and Public Health, Australia.

Kenneth has ethical clearance from the Kintampo Health Research Centre's Institutional Ethics Committee (approval certificate number **KHRCIEC/2018-25**) to carry out this study.

Kenneth will need to identify people living with mental health problems as well as their carers from the municipal mental health psychiatric case registers for interviews to gain an understanding of mental health service provision in the area as well as the progress made through the implementation of the 2012 Mental Health Act in Ghana.

As a student project, I kindly ask of your assistance in facilitating the identification of the cases and their carers for Kenneth to be able to collect data for this research which has a potential benefit of recommending measures for improving mental health care provision in the Municipality.

Please don't hesitate to contact me should you require further information about this research. Counting on your support and cooperation.

Yours sincerely,

MS ALICE A. VORLETO
AG. MUNICIPAL DIRECTOR OF HEALTH SERVICES

MUNICIPAL DIRECTOR
GHANA HEALTH SERVICE
KINTAMPO NORTH
KINTAMPO B/A

KINTAMPO PSYCHOSOCIAL CENTRE
KINTAMPO MUNICIPAL HOSPITAL
KINTAMPO HEALTH RESEARCH CENTRE
COLLEGE OF HEALTH AND WELL- BEING

APPENDIX H KHRC approval of protocol

In case of reply the Number and date of this letter should be quoted.

My Ref: khrc/adm/2018-10
Your Ref. No

Kintampo Health Research Centre
Ghana Health Service
P. O. Box 200
Kintampo
Brong Ahafo Region
Tel: 03520 92038

25th October, 2018

The Principal Investigator,
Mental Health Act in Ghana Study,
Kintampo Health Research Centre,
P.O. Box 200,
Kintampo.

Dear Principal Investigator,

Decision on your protocol

The Kintampo Health Research Centre's Scientific Review Committee reviewed your protocol entitled **"Implementation of Mental Health Act in Ghana: A study of potential barriers and enablers using a mixed method approach"**.

It is my pleasure to inform you that the protocol has been given full approval by the Scientific Review Committee (SRC).

You are required to submit a copy of the final protocol to the Kintampo Health Research Centre Institutional Ethics Committee for ethical approval before commencement of the study.

Accept my congratulations

Yours faithfully,

Charlotte Tawiah Agyemang
(Vice Chairperson)

APPENDIX I Information poster

MENTAL HEALTH ACT IMPLEMENTATION

Right to Mental Health: Implementation of the Mental Health Act in Ghana

RESEARCH STUDY

www.newcastle.edu.au

Researchers at the University of Newcastle (UON), Australia and the Kintampo Health Research Centre, Ghana are calling for mental health key stakeholders to participate in a study on challenges facing the implementation of the 2012 Mental Health Act in Ghana.

This research assesses the extent to which the provisions of the Act are being implemented across Ghana, and to document the barriers and enablers to implementation and offer strategic recommendations to enhance further progress. The study will also assess the feasibility of integrating traditional and faith-based healers into the care of people living with mental disorders without infringing on their rights as has been the practice in the past.

Mental Health key stakeholders including service providers, caregivers and users are all invited to participate in the study.

The study will investigate the barriers and enablers for the implementation of the 2012 Mental Health Act 846 in Ghana, with the goal of service improvement for people living with mental disorders.

For more information about the study, or If you would like to participate in the study, please contact Kenneth Ae-Ngibise at the Kintampo Health Research Centre, PO Box 200, Kintampo or email: Kenneth.AeNgibise@uon.edu.au, phone: +233244977845 to arrange an interview or focus group time. Additional information about this study can be obtained from the principal investigator, Prof Mike Hazelton, School of Nursing and Midwifery, University of Newcastle, Australia, Phone: +61 448121012, Email: Michael.Hazelton@newcastle.edu.au.

The sources of funding for this project are from The School of Medicine and Public Health Student Research Training Scheme, the Priority Research Centre for Health Behaviour, University of Newcastle Australia and the Kintampo Health research Centre, Ghana.

Complaints about this research

The Ethics Committees of both the Kintampo Health Research Centre and the University of Newcastle reviewed and approved this research with the approval numbers KHRCIEC/2018-25 and H-2018-0424 respectively. These committees are responsible for ensuring that participants rights are protected. If you have questions or issues about your rights as a research participant, kindly contact the Administrator of Kintampo Health Research Centre Institutional Ethics Committee, by telephone at +233 504270501, email fred.kanyoke@kintampo-hrc.org or the Human Research Ethics Officer, Research

Services, NIER Precinct, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone +61 49216333, email human-ethics@newcastle.edu.au.

APPENDIX J Prayer camp observation checklist

Prayer Camps Observations Checklist

The following checklist guided the observation at the prayer camps.

Permission and consent

Permission and consent to observe the prayer centre was obtained prior to the date for the observation. The was done through the prayer camp leaders and to double-check on the day of the field observation.

Type of Observation

Unstructured – No pre-determined structured study guide but key guiding principles to be observed holistically documenting whatever goes on in the prayer centre with respect to the healing procedures and processes. Holistic view.

Observers

Two Researchers (PhD student and a graduate student, both trained and with enormous qualitative research expertise) to conduct the observation.

Focus or Coverage of Observation

Patients (especially those with mental illness) at the prayer camps, including the prayer leaders, are observed. Those who opt-out or do not wish to be part to be excluded. These people were to wear red wrist bands to be easily identified as excluding from observation.

Expected duration for observation

06:00 GMT to 18:00 GMT [12 - Hour period], with 1 hour lunch break.

On the day of the observation

- Researchers (Observers) to arrive earlier on time for the observation
- Document your first impression from a trained researcher and health professional's position on one side and then from your value system.
- Observers need to be sensitive to the apprehensions and perspectives of people in the prayer camp.
    - Initial impressions of the environment – Smells and sounds of the physical environment.
    - The appearance of the people, dress, their number, gender, age, movement and behaviour patterns.
- Routines in the prayer centre, similarities and differences in behaviour
- Activities and behaviours that stand out as significant or unexpected. Be open-minded and control personal reactions and biases.
- Focus specifically on how people react to unexpected events through their responses
- Gossips and talked about in the prayer centre.
- Physical and emotional responses

What to observe on the day?

Activities, behaviours, actions, conversations, interpersonal interactions, organisational structure, community processes, or any other aspect of observable human experience in the prayer centres:

- Information consists of detailed field notes.
- The open-mindedness of the observers
- Cross-validate and triangulation of information available
- Capture participants' views of their experiences in their own words.
- Building trust and rapport during entry to the prayer centre.
- Staying alert and discipline during the observation period
- Moving around the whole centre to observe and document information relevant to the research
- Conscientiousness in taking detailed field notes at the prayer centre.
- Observers to provide preliminary feedback as part of verifying the information captured.
- Observers were to get involved in some of the daily activities in the centre as appropriate while keeping in mind the purpose of the visit.
- Observe for cultural or linguistic differences
- Interview some people in the prayer centre
- Validate information got from the prayer centre with other sources where necessary

Closing for the day

- Summarise key issues observed and get feedback from the centre leadership
- Reflect on what had been observed and write detailed notes/report immediately after the observation.
- Document researcher personal feelings regarding the observations which may affect the observation