Ministry of Health
Ghana

Twelve-Year Mental Health Policy 2019 - 2030

Ensuring a Mentally Healthy Population

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Foreword

A healthy population is a wealthy population. Mental health is total health. It is a right and a goal and it is, indeed, central to the socioeconomic development of a country. The first Mental Health Policy for Ghana was developed in 1994 revised in 1996 and since then significant changes have occurred in the global, national and health sector landscapes which have impacted on mental health. It is six years since the Mental Health Act, 2012 (Act 846) was enacted culminating in the establishment of the Mental Health Authority (MHA). A lot of progress has since been made in the delivery of mental health services in the country though many challenges persist. It is within this context that this new policy has been developed. The policy views mental health as an important indicator of the health status of the people living in the country. While focusing on community care, the policy sets out the new direction for the general improvement in the quality of mental health of the citizenry. In addition it maps out the institutional framework for its implementation. The policy details a programme to complete the establishment of governance structures like the Mental Health Tribunal, Visiting Committees, District Mental Health Subcommittees and appointment of District Mental Health Coordinators. With the establishment of these structures the Authority can fully implement the provisions of the Mental Health Act including ensuring human rights compliance.

Government is committed to funding mental health services in the country to ease the financial burden of the Authority and empower it to embark on its numerous projects to improve on the mental health of Ghanaians to the level of an advanced middle income country.

This Policy recognizes the role of various stakeholders and other sectors and we implore on all and sundry to wholly embrace it and contribute to its implementation.

Hon. Kwaku Agyemang-Manu (MP)

Minister for Health

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Gratitude is expressed to Mr. Emmanuel Owusu-Ansah who was contracted as MHA consultant to craft the policy draft out of the situational analysis and other reports for further deliberations. The administrative assistance provided by Ms. Gifty Naa Clottey and all the staff of the Authority is duly acknowledged.

There were other individuals and organizations who also contributed immensely in the development of this policy and due acknowledgment is given them. The full list of individuals and organizations who contributed to the development of this policy is found in Appendix IV.

List of Acronyms

BCC	Behaviour Change Communication
BoD	Burden of Diseases
CBO	Community Based Organization
CE	Chief Executive
CHAG	Christian Health Association of Ghana
CHPS	Community-Based Health Planning &Services
CHO	Community Health Officer
CMHO	Community Mental Health Officer
CPN	Community Psychiatric Nurse
DACF	District Assembly Common Fund
DALYs	Disability Adjusted Life Years
DCE	Deputy Chief Executive
DfID	Department for International Development, the United Kingdom
DHS	Demographic and Health Survey
FDA	Food and Drugs Authority
GDP	Gross Domestic Product
GHS	Ghana Health Service
HeFRA	Health Facilities Regulatory Agency
HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immuno-Deficiency Syndrome
ICT	Information Communication Technology
IoM	Institute of Medicine
LB	Live Birth
LEAP	Livelihood Empowerment Against Poverty
MASLOC	Microfinance and Small Loans Centre
MDGs	Millennium Development Goals
MNS	Mental and Neurological Disorders

MOH	Ministry of Health
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NRCD	National Redemption Council Decree
OPP	Out-of-Pocket Payment
PPME	Policy Planning, Monitoring and Evaluation
SDGs	Sustainable Development Goals
TAMC	Traditional and Alternative Medicine Council
TAM	Traditional and Alternative Medicine Directorate
UHC	Universal Health Coverage
WHO	World Health Organization

Executive summary

This Twelve-Year Policy is the third to be developed for mental health service. The first was developed in 1994 and the second was a 1996 revision of the first one. The 1994 maiden policy was a series of recommendations to be implemented by the Ministry of Health for mental health service. It included the formation of a Coordinating Inter-Ministerial Technical Committee. A cursory evaluation of that policy indicates that most of the recommendations were not implemented and that called for the review of the policy two years later. Unfortunately the review policy too was largely not implemented.

This current policy represents the first policy of the Ministry of Health, led by the Mental Health Authority and initiated by the governing body, the Mental Health Board. Since the creation of the Board in 2013 following the enactment of the Mental Health Act, 2012 (Act 846) attempts have been made to come out with a Twelve-Year Policy. This policy is intended to look at the weaknesses, strengths and opportunities of the system of mental health care and for a vision of standard and modern mental health care for the next twelve years, 2019-2030.

The purpose of this policy is to provide a framework for supporting achievement of good mental health for people living in Ghana while being sensitive to culture, resources and geography, amongst other considerations. This clearly articulates a vision of ensuring a mentally healthy population of Ghana.

The policy covers promotion of mental health, prevention and management of mental health conditions for all persons across the life span, both in the public and private sectors. It covers substance use disorders including alcohol abuse, but does not include conditions that are purely neurological without mental health conditions, like epilepsy when there is no mental health complication.

The policy is aligned to national and international contexts and also health sector-wide perspectives of Ghana. It is equally aligned to the legal context, including the 1992 Constitution of Ghana and the Mental Health Act, 2012 (Act 846).

Formal mental health care in Ghana dates back to the 1800s with the enactment of the Lunatic Asylum Ordinance in 1888 which criminalized severe mental illness. Persons with severe mental illness were arrested and put in special prisons. Since then efforts have been made to make mental health care more humane with the enactment of the NRCD 30 of 1972.

Currently mental health service in Ghana is bedeviled with a lot of challenges. These include human rights abuses, lack of human resources, poor financing, over-centralization, institutionalization, poor infrastructure, lack of logistics like medications and over reliance on the medical model to the detriment of the psychosocial care. It adopts the ‘top-heavy’ model where most resources are located centrally at the long stay facilities leaving the communities underserved. This policy aims at addressing these challenges to make mental health care more modern in line with middle income country mental health care.

This Policy was developed through the engagement of local and international consultants and other stakeholders in a series of meetings and validation exercises. There are five objectives identified for

planning and these have been expanded to 12 policy thrust areas with specific objectives. These policy thrust areas include service delivery, financing, human resource, governance and partnership and human rights, among others. There are policy objectives, specific objectives, strategies to achieve these and key results areas provided under each policy thrust.

The implementation framework, which captures the key stakeholders and their roles in the implementation of the policy, has been provided. The framework has been divided into three terms – a short term of three years, medium term of three years and a long term of the next four years.

The monitoring and evaluation strategies, just as communication channels, have been adequately dealt with. The modes of evaluation and monitoring include peer review mechanisms and reports from facilities and other surveys that will be conducted. Additionally short term, medium term and terminal evaluations will be done. The communication channels include reporting through DHIMS, quarterly, semiannual and annual reports, workshops, seminars, conferences, durbars and public meetings at churches and mosques, among others. Reporting and feedback will follow the same process.

The strategies provided at each of the Policy Thrust are summaries that can guide the implementation of the Policy and the achievement of the results areas. Detailed strategies including costing and communication plan will be developed in a separate Mental Health Strategic Plan (2018-21) which is currently being worked on.

Chapter 1: Introduction

1.1 Background and Rationale

Throughout the history of humanity, mental health conditions have existed in one form or another ranging from minor conditions, such as stress, to major conditions such as psychosis and depression with suicidal tendencies. Globally, an estimated 3% of the population suffers from mental health problems. Out of this, psychosis constitutes 0.5-2%, adult depression and anxiety 5-15% while childhood mental disorders take up 10%.[1,2] Mental disorders account for four out of ten leading causes of disability worldwide. WHO predicted in 2001 that depression would be the leading cause of burden of disease by 2020 but already in 2018 depression has reached that level.[3] Ghana is no exception to this phenomenon.

In 2005, WHO estimated that, of the then 21.6 million Ghanaians, 2.1 million suffered various kinds of mental health conditions of which 650,000 were severe.[4] A 2009 study, showed 41% Ghanaians had one or another form of psychological distress and this contributed to 7% GDP loss.[5] Ghana's mental health service has generally been under resourced and its response to mental health needs has not been adequate[6] and mental health staff have had to take to the streets to demand resources to operate. Human resources have been inadequate. For a population of 29 million there are only 25 psychiatrists, 30 clinical psychologists, seven Occupational Therapists and 2500 psychiatric nurses. There are only three public psychiatric hospitals, all located in the southern part of the country.

These hospitals face infrastructural challenges with no major renovation since their establishment. Human rights of patient continue to be abused with traditional and faith-based healers locking up patients in chains and shackles. Persons with mental health conditions face stigma and discrimination on daily basis.

In recognizing above and other shortcomings, Ghana has made efforts, to address some of these challenges. These efforts include the development of first and only Mental Health Policy in 1994 revised in 1996, the ratification of the United Nations Convention on the Rights of Persons with Disability (CRPD), enactment of the Mental Health Act, 2012 (Act 846), and integration of mental health into general health care with the opening of psychiatric wings in some Teaching and Regional Hospitals.

1.2. Problem Statement

Notwithstanding the commendable efforts to improve mental health care in Ghana there still remain serious challenges: Mental health care currently is not adequate in its quality and spread. Services are skewed to the southern part of the country and saddled with inadequate logistics, human rights abuses, stigma and discrimination. What pertains now is virtually the inverted pyramid of care with 'top-heavy' concentration of services and resources at the psychiatric hospitals as against the optimal pyramid where services and resources are spread in the community (See Appendix III). Services are overly centralized with undue concentration on medical model leaving out psychosocial care. Staff attitude is poor as they are not adequately motivated. Mental health care is seen as the preserve of the Ministry of Health and more specifically as the exclusive responsibility of the Mental Health Authority.

The Government of Ghana is, therefore, setting out this inter-sectoral mental health policy as a framework to capture the vision informing the Mental Health Law[7]. This policy is designed to support good mental health services in Ghana in a way that is integrated, holistic, decentralized and culturally sensitive.

This policy, with its corresponding strategic plan soon to be developed, takes cognizance of current worldwide developments in mental health, to transform the way mental health problems are dealt with in the Ghanaian society across the life span in consonance with Ghana's middle income status.

1.2 History of Mental Health Services in Ghana

Persons with severe mental health conditions began to receive attention in the colonial days when the Prisons Ordinance was passed in 1876. This Ordinance declared that persons with mental health conditions roaming the streets were to be arrested and put in prison as criminals. When their numbers increased in the prisons a special prison was established for them, the Victoriaborg Asylum in Accra in 1887.[8]

Later the Lunatic Asylum Ordinance of 1888[9] was passed specifically for persons with severe mental health conditions. This legitimized Victoriaborg Asylum and paved way for other asylums to be built. The Ordinance formalized mental health care though this care remained custodial and penal; persons with severe mental health conditions were arrested and incarcerated as criminals or special

prisoners. Stigma with its associated discrimination against persons with mental health conditions was very high.

At the beginning of the 20th century, mental health conditions began to be seen as a health problem. Accra Psychiatric Hospital (then called Accra Asylum or Central Asylum) was established in 1906 as a special prison for persons with severe mental health conditions. Inmates from Victoriaborg Asylum were transferred there and the Victoriaborg Asylum was closed down. In 1960 Senchi Resettlement Centre near Atimpoku in the Eastern Region was created as an asylum annex to decongest the Accra Asylum.

Subsequently, Ankaful and Pantang Psychiatric Hospitals were built in 1965 and 1975 respectively, and specifically as hospitals but with emphasis on institutional care. Inmates of the Senchi Resettlement Centre were transferred to Ankaful in 1965 and the Resettlement was closed down. In line with the concept of patient care for persons with mental health conditions, NRCD 30 was passed in 1972 to repeal the 1888 Lunatic Asylum Ordinance.

Following the WHO's *Alma Ata* declaration in1978, efforts have been made to increase access to mental health care through community care. The first mental health policy in Ghana was developed in 1994 and revised in 1996. A Four-Year Strategic Plan was drawn for 2008-2011 followed by another Four Year Strategic Plan 2014-2017.[10] Sadly, on account of lack of funds, these were not implemented beyond the routine mental health activities.

The enactment of the Mental Health Act, 2012 (Act 846), created the MHA as an agency of the MoH to be responsible for mental health care. A Mental Health Board was established on 19th November 2013 as its governing board, necessitating the development of the policy to realize the vision enshrined in the new law.

1.3 Rationale for the Policy

- Good mental health contributes positively to physical health, family life, education, social participation and economic development;
- Mental health conditions worsen the health outcomes of both communicable and non-communicable diseases;
- Mental health conditions are a significant contributor to mortality through premature deaths from physical disorders and suicides from the mental health conditions, especially depression;
- Mental health conditions reduce life expectancy by ten to twenty years;[11,12]
- Mental health policy and action plans coordinate, through a common vision, all programmes and services related to mental health; and
- There is the need to develop a new policy to align with the policy of the MoH and to address current developments in global mental healthcare such as ensuring respect for the rights of persons with mental health conditions.

1.4 Purpose

The policy provides a framework for achieving good mental health for the population of Ghana, taking into account the culture, resource, geography and experiences in mental health services delivery.

1.5. Scope

This policy covers promotion of mental health, prevention and management of mental health conditions. The scope covers management of substance use disorders including alcohol abuse but does not include conditions that are purely neurological without mental health complications. Thus epilepsy without mental health complications is not covered by this policy.

Founded on evidence-based practice, multi-sectoral and life span[13] approaches, the policy covers both public and private sectors including non-governmental sectors. Similarly it covers both orthodox and alternative services like traditional and faith-based healing.

The policy aligns with Ghana's health policy and the policies of non-health sectors. It is also rooted in international principles of human rights and Universal Health Coverage (UHC).

1.6 Policy Development Processes

In 2016, the Mental Health Board commissioned the drafting of a new policy, DfID provided technical support through Oxford Policy Management (OPM), a UK-based policy management consulting firm. OPM recruited a team of international and local consultants to draft the policy. These consultants travelled across the country to carry out extensive interviews of users and carers. They engaged in wide consultation with stakeholders in the health and some non-health sectors to develop the policy. The consultants interviewed the sector Minister and key staff of the MoH. Also interviewed were the Ministers for Gender, Children and Social Protection, Justice and Attorney General and Finance and their key staff. Professional groups and traditional healers were also interviewed.

In addition, the consultants interviewed Non-Governmental Organisations (NGOs) in mental health such as BasicNeeds Ghana, Mind Freedom Ghana, Psycho-Mental Health International and Mental Health Society of Ghana (MEHSOG). Other stakeholders consulted included Ghana Health Service (GHS), Christian Health Association of Ghana (CHAG), Teaching, Psychiatric, Regional and District Hospitals, primary care centres and the academia

An objective appraisal of the current state of Ghana Mental health service was produced from the stakeholder consultations. The appraisal, which was reviewed by key stakeholders including WHO (Country and Regional Offices), highlighted the service's strengths, weaknesses, challenges and opportunities, and made recommendations on the way forward.

A policy draft was then crafted out of this appraisal under the leadership of a local consultant appointed by the MHA and series of meetings were held with stakeholders and the final product was reviewed by the Policy Planning, Monitoring and Evaluation (PPME) Division of the Ministry of

Health and the National Planning and Development Commission (NDPC) for their input to arrive at a final document. Details of the process of this policy development are provided in Appendix I.

1.7 Structure of the Policy Document

This document has been divided into five chapters. Chapter One gives a background and rationale to the development of the policy, the history of mental health services in Ghana, the process of the policy development, the scope, purpose and guiding principles to the policy. Chapter Two deals with the context of the policy from the international, national, health sector and legal perspectives. It also includes the situational appraisal of mental health services including a brief history of mental health care in Ghana and the key challenges of these services from the perspective of service delivery, financing and human resource, among others.

Chapter Three looks at the thrust of the Policy. It includes the vision, mission, goal, key policy areas, policy objectives, strategies and key results areas. Some of the policy thrust areas include service delivery, financing, human rights, health technology, governance and partnerships, among others. Chapter Four looks at implementation framework which maps out the key stakeholders with a role in the implementation of the policy. The last chapter, Chapter Five, deals with the monitoring, and evaluation processes and a communication strategy. An appendix of implementation schedule is provided with a time frame assigned for each of the key results areas. Also included are appendices of the processes of development of this Policy document, the pyramid of care as recommended by the WHO and the pyramid of care on the ground.

The strategies listed under each Policy Thrust provides a summary to guide the implementation of the Policy and the achievement of the results areas. Detailed strategies, the costing and the communication plan will be developed in a separate Mental Health Strategic Plan (2018-21) which is currently being formulated.

1.8 Guiding Principles

The guiding principles for this policy are:

- Evidence - mental health interventions will be evidence-based with quality improvement measures;
- Decentralisation - mental health services will be delivered at all levels of care, especially at the lowest level;
- Integration - mental health services will be organised seamlessly within the general health care;

- Holistic care – services will take into consideration the biopsychosocial model of mental health care by providing for a comprehensive multi-disciplinary mental health package;

- Equity – services will be provided to all across the life span (covering all ages) to ensure geographical accessibility of the service, prioritizing the needs of the most vulnerable population, promote gender sensitivity and allocate resources fairly to mental health, both from the MoH to mental health and within mental health to various areas of need;

- Affordability – access to mental health services will take into account the socio-economic circumstances of the client and thereby make provision for the poor to have their mental health care needs provided;

- Human rights - uphold the dignity, autonomy, freedoms and equal opportunities universally accorded to human beings including socio-economic opportunities, civil and political rights and the right not to be discriminated against;

- Empowerment – persons with mental health conditions will be involved in advocacy, policy planning and implementation, service delivery as well as monitoring and evaluation of programmes;

- Partnerships – the policy recognises that there is a wide range of stakeholders involved in mental health care including Ministries, Departments and Agencies (MDAs), private partners, NGOs, media, development partners and civil society. The policy taps into all these varied resources; and

- Confidentiality – persons with mental health conditions are entitled to confidentiality of information about them except as required by law to divulge.

Chapter 2: The Context

2.1 The Global Context

The importance of mental health has been recognized by the global community as an integral part of health. Both the WHO Constitution of 1946 and the *Alma Ata Declaration* of 1978 gave prominence to mental health in the definition of health as a state of complete physical, mental and social wellbeing of people and not merely the absence of disease or infirmity. The cited WHO Constitution envisages "the highest attainable standard of health as a fundamental right of every human being."

Article 12 of International Covenant on Economic, Social and Cultural Rights (ICESCR) grants every human being including persons with mental health conditions the right to health, while Article 11 and General Comments 14 also proclaim the right to adequate standard of living including adequate clothing and housing, and continuous improvement of living conditions.

Article 25 of the UN Convention on the Rights of Persons with Disabilities states that 'persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.'

From the international provisions above, health is a right and a goal in itself and not merely a means to an end. Right to health, as a goal, means that availability, accessibility, acceptability and quality of service should be guaranteed.

Global initiatives affirm the contribution of mental health to the achievement of Universal Health Coverage (UHC) and sustainable human development. Although the Millennium Development Goals (MDGs) did not make specific mention of mental health, mental health was relevant for the achievement of all the goals. Agenda 2030 of the Sustainable Development Goals (SDGs) subsequently made specific mention of mental health in specific targets and goals (see Box 1).

Box 1: Agenda 2030 of the Sustainable Development Goals

Target 3.4: "By 2030, reduce by one third premature mortality from non-communicable disease (NCDs) through prevention and treatment and promote mental health and wellbeing"

Target 3.5: "Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol".

SDGs (especially 1, 5, 8, 10): highlights on poverty reduction, gender, economic development, reducing inequalities and also requires attention to mental health promotion, prevention and treatment of Mental Neurological and Substance use (MNS) disorders, as MNS disorders are highly associated with poverty, financial hardship and debt, low productivity, and are generally more common in women, ethnic minorities, people with disabilities, and other marginalized groups.

In 2013, the 194 member states of the World Health Assembly adopted the Comprehensive Mental Health Action Plan 2013-2020 (resolution 66.8), recognizing the importance of mental health and declaring commitment toward the goal *to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce mortality, morbidity and*

disability for persons with mental disorders and set out indicators to monitor implementation, progress and impact of the resolution.[14]

These global initiatives mandate the development of a national policy for mental health services.

At the regional and sub-regional levels, the Policy is aligned to African Union Agenda 2063 and West African Health Organization (WAHO) Strategic Plan 2018-2025 which seeks to, among other goals, ensure that mental health is incorporated into emergency preparedness plans; collaborate with traditional and faith-based healers and ensure integration of perinatal mental health into routine antenatal as well as maternal and child health programmes. It is equally aligned to the WHO Mental Health Action Plan of 2013-2020.

Ghana has ratified various international treaties on the rights of its citizens, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of Persons with Disability (CRPD)

2.2 The National and Legal Context

Article 15 of the 1992 Constitution of the 4th Republic of Ghana gives the constitutional roots for a national policy based on human rights and demands respect for human dignity, including freedom from torture and cruelty, Article 17 of the same Constitution demands equality and freedom from discrimination, Article 26 (2) prohibits customary practices that are dehumanizing, Article 29 talks of the rights of the disabled, Article 30 seeks the rights of the sick, Article 33 (1) enjoins the courts to protect rights, 33 (5) promotes and protects dignity of all persons, and is an omnibus clause which allows changes or continuous improvement with time.

Ghana's Medium Term Development Policy Framework (Agenda for Jobs: Creating Prosperity and Equal Opportunities for All (2018-2021),) also makes provision for accelerating implementation of Mental Health Strategy and Law (GOG, December 2017). It is within Ghana's Coordinated Programme of Economic and Social Development Policies to ensure a healthy population capable of contributing fully to national socio-economic development[15]. This programme entails special attention to be paid to Mental Health. The policy is aligned to various policies of the Ministry of Health including the National Health Policy of 2007 and current draft policy of 2020-2030.

Specifically the constitutional provisions human rights based mental health care are captured in Section 3 of the Mental Health Act, 2012 (Act 846) which talks about protecting, respecting and fulfilling the human rights of persons with mental illness.

Changes in Ghana's population, economy, culture and social intervention programmes affect not only the prevalence of mental health conditions but also access to quality services. Ghana's population estimated in 2010 was 24.6 million, largely youthful, predominantly female, more urbanized and aging.[16] In 2018 the Ghana Statistical Service estimated the population at 29.6 million. These demographic features have implications for the mental health of the populace.

Over the past few decades Ghana's economy has experienced high growth accompanied by significant reduction in poverty. Average per capita growth rates exceeded 2.5 percent between 1983 and 2006, increasing to an average of 6 percent between 2006 and 2011. In 2008, Ghana became a

lower-middle income country (LMIC) when it hit a GDP growth of 9% after rebasing. In 2011 Ghana began commercial oil production. Poverty declined from 52 percent in 1991 to 21 percent in 2012.

Notwithstanding the general improvement in the economy of the country, growing inequalities in incomes and other resources are creating disparities in access to social programmes including health. In 2012, more than a third of the nation's poverty was concentrated in the three regions of the north, though these regions together comprise only 17 percent of the population. A significant proportion of the population is at risk of sliding back into poverty in the event of a major economic setback.

The GoG has a comprehensive National Social Protection Strategy and a National Social Protection Policy. These strategies articulate the government's vision to create sustainable mechanisms to protect people living in extreme poverty and who face vulnerability or social exclusion. The Ministry of Gender, Children and Social Protection (MoGCSP) coordinates and oversees social protection in the country. Among the social protection programmes is the Livelihood Empowerment Against Poverty (LEAP) which is a cash transfer programme for the extremely poor households and persons with severe disabilities. However, there is the need to better target the programmes and expand their coverage to officially include persons with mental disabilities.

Culture and religion influence the value the society places on mental health, the understanding of causative factors, the management of the condition, the degree of stigma and discrimination, access to services and pathways to care. Culture does not only affect the presentation of symptoms but also the help-seeking behavior. In cultures where mental illness is believed to be caused by the supernatural, clients tend to patronize traditional and prayer healing centres as the first point of call rather than allopathic facilities. This policy has taken these factors into consideration.

The policy hinges on an Act of Parliament, the Mental Health Act, 2012 (Act 846) which repealed the NRCD 30 of 1972, which in turn repealed the 1888 Lunatic Asylum Ordinance, No. 3, Cap 79. The tenets and vision envisaged in Act 846 as the governing law of mental health service in the country inform the policy.

2.3 The Health Sector Context

Ghana is in an epidemiological transition with a high prevalence of communicable diseases and yet a growing prevalence of non-communicable diseases such as diabetes and hypertension. Mental health conditions are now a significant non-communicable disease afflicting the nation. Depression, for instance, was found to be number16 cause of Disability Adjusted Life Years (DALY[1]) in 2013. [17]

Ghana is committed to providing universal health coverage for its population while reducing financial barriers to accessing care. Article 34 (2) of the 1992 Constitution of the Republic of Ghana provides for the right to good health care. Also, Ghana has a draft 40-year National Development Framework (2018-2057) that provides for social development policies, including health care. [18] The goal of the health sector is to ensure healthy lives and well-being for all persons in the country.

[1] DALY is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.

The MoH provides policy direction, mobilizes resources, monitors and evaluates the sector's performance and coordinates activities of partners and Agencies. The MHA is an Agency of the MoH mandated to propose, promote and implement mental health policies; and provide culturally appropriate, humane and integrated mental health care in Ghana. The MHA has both regulatory and service delivery roles. As a regulator, it ensures best practice of mental health delivery by all service providers throughout the country while in its other role it provides service through the three psychiatric hospitals.

Health services including mental health are provided by a range of allopathic and traditional practitioners, the largest allopathic providers being GHS and CHAG. Additional providers are the Teaching hospitals, quasi-governmental hospitals and private institutions including the Islamic facilities faith-based and traditional healers.

Some initiatives have been embarked on to improve quality of care in the health sector including mental health. A National Healthcare Quality Strategy and the National Patient Safety Policy have been developed by the MoH to provide a framework for quality improvement.

Decline in government inflows to the health sector has negatively impacted on service delivery including mental health. Per capita national expenditure on health decreased from US$32.8 to US$24.8.[19] Delays in reimbursing providers by the National Health Insurance Scheme have compounded these challenges though the situation is improving.

The existing policy of the Ministry of Health has the theme, "Creating Wealth Through Health, September 2007."[20] This policy has five objectives illustrated in Box 2.

Though the inclusion of mental health under Objective 5 for Institutional Care seems to subsume mental health under institutional care, it was actually the first time mental health was specifically mentioned in a national health policy.

Box 2: Health Sector Objectives.

- **Objective 1** Bridge equity gaps in access to health care and nutrition services and ensure sustainable financing arrangements that protect the poor
- **Objective 2** Strengthen governance and improve the efficiency and effectiveness of the health system
- **Objective 3** Improve access to quality maternal, neonatal, child and adolescent health services
- **Objective 4** Intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles
- **Objective 5** Improve institutional care including mental health service delivery

The MoH is, however, developing a new policy with the theme: 'Ensuring the Right to Health through Universal Health Coverage, 2020 – 2030.' This policy, still in a working document form, aims at achieving the goal of the health sector through pursuing the following mutually interrelated and reinforcing sector objectives:

1. Provide sustainable, affordable, equitable, easily accessible essential health services (Universal Health Coverage (UHC) to all at all ages.
2. Reduce morbidity, disability, mortality and intensify prevention and control of non-communicable diseases
3. Enhance efficiency in governance and management of the health system
4. Intensify prevention and control of communicable diseases and ensure the reduction of new HIV and AIDS/STIs infections, especially among the vulnerable groups

Mental health care finds itself in Objectives 2 and 3.[21]

In the medium term the Ministry will develop the four-year Health Sector Medium Term Development Plan (HSMTDP) to guide the development of the annual Programme of Work.[22]

2.4. Mental Health Situation in Ghana[23]

2.4.1. Disease Burden

The few prevalence studies on mental health in Ghana are not generalizable as they are not epidemiologically robust. There are, therefore, no reliable national or local population prevalence studies of mental disorders in Ghana.[24]

Routine data is incomplete and there are challenges with data quality. However, a number of prevalence studies done in Africa and elsewhere estimate the prevalence rate in children at 10% while about 1–3% of the adult population suffer from psychosis and 10% have common mental disorders (CMD) such as depression and anxiety. Furthermore, the prevalence of dementia among people aged over 60 years is about 3%. Assuming a district population size of 100,000 and taking into account the fact that half of the population is aged under 16, each district would have a minimum of 500 adults with psychosis, 5,000 adults with CMD, 5,000 children with other types of mental health conditions and 200 with dementia.[25]

Risk factors associated with higher rate of mental disorders in adults include socio-economic factors like unemployment and low earnings, teen parenthood, relationship problems, criminal activity and imprisonment. In children, the risk factors include: child abuse, low income status of parents, single parents and parental psychopathology among others.[26,27] Educational under achievement can also be a risk factor. There are also biological risk factors like genetic factors, gender, birth injuries and some childhood physical diseases. On the other hand good parenting, stable family, adequate income status, parental mental stability, among others, are protective factors against developing mental health conditions.

The financial burden of mental health conditions in Ghana has been estimated. For an affected household in Ghana, the average cost of mental health conditions is in the neighbourhood of US$60.24 per month. Direct cost takes 26% and is largely borne by the cost of drug. Indirect cost accounts for 74% and this is largely from productivity losses from lost employment and costs of care-giving.[28] At the national level, a rate of 41% psychological distress (mild, moderate and severe) has been found in Ghanaians with an estimated financial cost of 7% GDP loss to the nation. Moderate to severe psychological distress, enough to be considered mental illness, constituted 21%.[29]

Notwithstanding this heavy financial burden, it is equally known that an investment of some US$3–4 per head of population per year can provide a package mental health care to reduce this burden.[30]

Challenges

As epidemiological and prevalence studies are lacking, coupled with inadequate public awareness of the nature and causes of mental health conditions, knowledge of risk factors is scanty and there is not much data to inform disease burden and therefore effective planning for inter-sectoral prevention strategies.

2.4.2. Service Delivery

The range of services provided in Ghana include promotion, prevention, treatment and rehabilitation. Mental health services in Ghana are delivered by the public and private sectors, including allopathic and alternative practices like the traditional and faith-based healing. The public sector services include the psychiatric, teaching and quasi-government hospitals, regional, district and faith-owned[2] health facilities. Some NGOs are involved in mental health promotion, prevention and rehabilitation through education, facilitation of outreach services, capacity building, research and provision of sustainable livelihood empowerment. On account of inadequate spread and lack of accessibility to formal mental health services, a bigger proportion of patients are seen in the community by traditional and faith-based healers.

Services are delivered by a team of psychiatrists, other medical doctors, clinical psychologists, clinical psychiatric officers, physician assistants, psychiatric nurses, community psychiatric nurses, social workers, occupational therapists and other categories of staff. These services are provided within health facilities and in the communities. Outpatient clinics in the general hospitals are usually provided by doctors or physician assistants who often refer new cases of persons with mental health problems to the Mental Health Units.

There are three public psychiatric hospitals, two based in Accra and one in Cape Coast, and these have a total bed capacity of 1,322 but sometimes in-patient population of 1,500 depicting congestion on the wards. Two Teaching Hospitals (Korle Bu and Komfo Anokye) have psychiatric departments with 12 beds each where patients can be admitted for about two weeks. Three Regional Hospitals (Sunyani in Brong-Ahafo Region, Ho in the Volta Region and Koforidua in the Eastern Region) have psychiatric wings with 10 to 20 beds which also allow short term admission of up to two weeks. These have at least a psychiatric prescriber each.

Four other Regional Hospitals (Tamale in the Northern Region, Wa in the Upper West Region, Bolga in the Upper East Region and Efia Nkwanta in the Western Region) have psychiatric units where patients can be detained for a few hours before they are admitted to the general wards or discharged home or referred. The three remaining Regional Hospitals (Central, Ashanti and Greater Accra) are yet to have psychiatric wings or units where patients can be admitted or detained.

There are four private psychiatric hospitals with a total bed capacity of forty supporting mental health care: two in Accra and two in Kumasi. Few public drug rehabilitation centres exist and these are: Pantang and Ankaful Psychiatric Hospitals. Rehabilitation Centres belonging to the Roman Catholic Church include Damien Centre at Fijai in the Western Region, Cheshire Home in Kumasi, Mercy Centre at Brafo Yaw near Cape Coast and House of St. Francis at Ashaiman near Tema. Other Centres include Shekinah Day Centre in Tamale in the Northern Region and Oxford House at Oyarifa near Accra, among others.

Forensic services cater for the mental health needs of persons in the criminal justice system. These include persons found to be mentally ill before conviction, convicts in prison found to be mentally ill or persons who the courts want an assessment of their mental state before trial. Though these services are provided in all three psychiatric hospitals, only Accra Psychiatric Hospital has wards

[2] Faith-owned health facilities are the health facilities owned by the religious groups. These include facilities of Christian Health Association of Ghana (CHAG) and Ahmadiyya Muslim Mission health facilities.

designated as forensic wards. The male such ward is often congested as the criminal justice system does not follow up with the patients some of whom have remained there for as long as 30 years.

Child and adolescent mental health services are scanty and, again only Accra Psychiatric Hospital has a designated ward for children. This ward is often taken up by neurodevelopmental cases like children with cerebral palsy and severe learning disability, rather than children with purely mental health problems. These children often end up being there for life and some have been there for twenty years or until their growing physical stature demands that they are sent to adult wards.

Just as with child and adolescent mental health services, geriatric mental health services (services for older persons) are inadequate and only Accra Psychiatric Hospital has designated wards for elderly males and elderly females. While all cases are attended to, there are no specialised services for subgroups like postpartum depression and posttraumatic stress disorders. Substance use disorders are beginning to have specialised treatment.

Community-based health services are provided by the GHS as part of the Community-based Health Planning and Services (CHPS) programme. The delivery of mental health services in the CHPS zones and compounds is managed by Community Health Officers (CHOs) in collaboration with Community Mental Health Officers (CHMOs). These are supervised by Community Psychiatric Nurses (CPNs) who also run outreach clinics in the communities. A number of NGOs facilitate community-based mental health services. These services include mental health promotion and awareness creation.

BasicNeeds Ghana, the most visible NGO in mental health in the country, in addition to promotion and awareness creation, also facilitates specialist outreach services, training of mental health staff, training of non-mental health personnel on mental health topics, sustainable livelihood for persons with mental illness and advocacy, lobbying to influence policies on mental health and training of traditional and faith-based healers. Furthermore it currently works with 500 self-help groups in selected regions, namely Northern, Upper East, Brong-Ahafo, Greater Accra and Central Regions.

Traditional and faith-based healers see a large number of people with mental health conditions. This care however is often associated with human rights abuses such as chaining, flogging, shackling and logging.

Challenges

Analysis of access to mental health services reveals disparities in socio-economic groupings and geographical areas. Most of the services are in the southern part of the country and even there, these services are limited to a few communities. In particular services for children, adolescents and older people are lacking across the country Moreover, systematic Quality Assurance is yet to be institutionalized.

2.4.3. Financing

Government pays for the salaries of all staff in the public sector including mental health personnel. Operational costs are also borne by the government. However, since 2013, most of the funding for mental health activities of the MHA has come from DfID. Through its Health Sector Budget Support Programme, DfID has given Technical Assistance support to the MHA, BasicNeeds Ghana, CHAG and lately GHS. Towards the end of 2017, the government provided GHC9 million to the MHA and the three psychiatric hospitals largely to offset part of their debts.

Challenges

Even though by law, mental health care is to be provided free of charge to patients to protect them from financial barriers, funds for running services from the central government have been limited. Since 2015 the psychiatric hospitals have had to find alternative means of funding through cost sharing with clients contrary to the spirit of the 'free-of-charge' policy, provision of ancillary services and expansion of services to include general or physical health care. The cost-sharing amounts to penalising clients.

Mental health has generally been underfunded. WHO-AIMS report of 2013 estimated that in 2011 the government of Ghana spent approximately 1.4% of the total health budget on mental health. This was much lower than the, at least, 4 percent of other low middle income countries.[31] Apart from compensation for staff in the community, there is no budget line for community mental health services. By the provisions of the National Health Insurance Act, 2003 (Act 650), as amended by the National Health Insurance Act, 2012 (Act 852), and the Mental Health Act, 2012, (Act 846) mental health is not covered by the NHIS; this presents a challenge to the clients who have to pay for their services out of pocket especially when these services are not available at the public facilities.

Another challenge is that most of the financing of mental health care is spent at the tertiary level leaving community and primary care severely under-funded. This underscores the decentralized and institutionalised care which needs to be reversed. Apart from the policy of free mental health care, persons with mental illness have little or no financial protection. Very recently, the Ministry responsible for social protection has been registering persons with mental illness under LEAP. The Ministry responsible for local government has also been including these persons under the disability fund. However, because the laws establishing these programmes do not expressly cover persons with mental illnesses, such persons cannot easily access these pro-poor interventions.

2.4.4. Human Resources

The human resource production of mental health staff has been improving consistently over the years. Until recently there were 600 Registered Mental Nurses (RMN). Since then, two thousand, one hundred (2100) of this category of nurses (RMN) have been added to the mental health workforce in the last five years.

MHA has facilitated the acquisition of financial clearance for the recruitment of occupational therapists, clinical psychologists and pharmacists. In-service training has been organized for front line community mental health workers, general doctors and physician assistants though a large gap exists.

Mental health is integrated into the curricula of all pre-service training institutions. The Ghana College of Physicians and Surgeons is training psychiatrists locally in addition to the training by the West African College of Physicians. While psychiatric nurses are being trained in two dedicated psychiatric nursing training schools (Ankaful and Pantang), some general nursing training schools are also training psychiatric nurses. These are Nalerigu and Yendi, both in the Northern Region, and Kwadaso SDA in Kumasi in the Ashanti Region. The College of Health and Well-Being Kintampo (formerly Kintampo Rural Health Training Institute) trains community mental health officers and clinical psychiatric officers (Physician Assistants in Psychiatry). Yamfo College of Health in the Brong-Ahafo Region is also training community mental health officers. This development has significantly led to an improvement in the mental health workforce, at least in the number of middle level cadres.

The MHA has appointed seven out of 20 Directors and Deputy Directors of the Authority. The appointment of 10 Regional Mental Health Coordinators has not only increased the visibility of mental health services in the regions, but also facilitated the decentralization process.

Challenges

Although the numbers of mental health staff have generally increased, distribution remains inequitable, to the disadvantage of the northern and rural areas of the country. In the three regions of the north, there are only two clinical psychologists, three clinical psychiatric officers and no psychiatrist. The relatively few human resources in the country are concentrated at the tertiary level care leaving the community and primary care under served. Among the reasons for this inequitable distribution are inadequate social infrastructure in, and lack of incentives to attract staff to the underserved communities.

Notwithstanding the significantly improved workforce, there is under-production of some categories of staff including occupational therapists, clinical psychologists, mental health social workers and psychiatrists. In addition, there is lack of established Continuing Professional Development (CPD) programmes to regularly update the knowledge and skills of staff.

2.4.5 Human Rights

Human rights abuses have been a blot on mental health care in the country. Human Rights Watch, an international NGO in human rights, devoted its whole annual report of 2012 on human rights situation in Ghana and described Ghana's mental health as 'a death sentence.'[32]

Since 10 October, 2017, on World Mental Health Day the MHA has formally banned chaining and shackling of persons with mental illnesses.[33] Regional Mental Health Coordinators are following up to ensure compliance. Visiting Committees, when established, shall further ensure the enforcement of the ban. The MHA has produced guidelines for the operation of traditional and faith-based healing centres to stop the human rights violations of persons with mental health conditions in these institutions. The Guidelines cover facility registration, education, appropriate housing, safety and security, clothing, feeding and other aspects of human rights guarantees. These guidelines have been validated by stakeholders including civil society groups like NGOs and human rights entities.

Apart from organizing public education and advocacy campaigns to reduce stigma and discrimination, the MHA has sensitized some traditional healers and families to stop the human rights violations of persons with mental health conditions. The MHA has also worked with some prayer camps and families to remove patients from chains, and has subsequently banned chaining even prior to the banning. Likewise civil society groups and CHAG have done a lot of work on training and sensitising traditional and faith-based healers, users and their carers.

Challenges

In spite of the progress made in improving the human rights situation of persons with mental health conditions, challenges remain. The only forensic ward in the country, which is at the Accra Psychiatric Hospital, is overcrowded. There are other human rights issues particularly in the traditional and faith-based healing centres where patients are chained or shackled, starved in the name of fasting, flogged or used for forced or inadequately remunerated labour, sexually harassed and sometimes even forced into marriages. The delay in the establishment of the Visiting Committees has made the monitoring of the ban on chaining a difficult assignment now.

2.4.6 Governance and Partnership

Some progress has been made in setting up the governance structures following the passage of the Mental Health Act. The MHA is governed by an eleven-member Board appointed by the President of the Republic of Ghana. A Chief Executive (CE) has been appointed who is part of the Inter-Agency Leadership Committee (IALC) of the MoH. This Committee meets quarterly and coordinates all activities of agencies within the Ministry. In addition, the MHA has a Department of Collaboration in its organogram that will be coordinating all relevant agencies including the private sector at the national level and other levels. The MHA has acquired an office space as its headquarters, appointed Regional Mental Health Coordinators and inaugurated the Regional Mental Health Sub-committees.

There is inter-sectoral collaboration between the MHA and other MDAs at the national level. Apart from collaborations through the IALC, the MHA collaborates with health training institutions and

agencies such as GHS, CHAG and the Teaching Hospitals in the training, implementation and provision of mental health services in the country. The MHA also collaborates with other regulatory bodies like the Medical and Dental Council for the regulation of medical doctors, psychiatrists, clinical psychiatric officers and physician assistants; Nurses and Midwives Council for the regulation of psychiatric and other nurses; the Traditional and Alternative Medical Practice Council for the regulation of traditional and faith based healers; Allied Health Council for the training and regulation of Community Mental Health Officers (CMHO) and the Ghana Psychology Council for the regulation of clinical psychologists in mental health care.

As part of government's decentralization programme, institutions exist at the regional and district levels for the coordination of all programmes including health. The Regional Coordinating Council coordinates at the regional level while the Metropolitan, Municipal and District Assemblies coordinate at their levels.

There are over 20 NGOs in mental health in Ghana including user associations. The most visible among them include BasicNeeds Ghana, MEHSOG, Epilepsy Association, World Vision, the Gub-Katimali Society, Friends of Mental Health, Alzheimers Association of Ghana, Autism Awareness Centre, Centre for People's Empowerment for Right Initiatives, Mission of Hope Society (MIHOSO), the Mental Health and Well-being Foundation, Voice Ghana, Ta-excel, Mind Freedom, Alcoholic Anonymous, Psycho-Mental Health International Ghana Mental Health Association and Country Alliance for Mental Illness (CAMI). The MHA collaborates with these NGOs for mental health delivery and promotion.

The MHA has engaged parliament and the Ministry of Finance towards the passing of the Legislative Instrument (LI), the establishment of the Mental Health Levy and the appointment of some key staff at national and regional levels.

Challenges

There have been delays in the reconstitution and inauguration of the MHA Board and this is having serious negative impact on the establishment and functioning of an Audit Committee, the signing of MOUs and the inauguration of various governance structures. The MOU with GHS will clarify the roles between the MHA and the GHS in staff distribution in GHS facilities and their responsibilities for mental health care at the regional and district levels.

There are no collaborations with other sectors of the private sector, like the Society of Private Medical and Dental Practitioners, Ghana Private Road Transport Owners (GPRTU) of the TUC, Society of Private Media and Broadcasters, Society of Private Educational Institutions and their Heads, etc.

On account of the absence of the Board and lack of funds, the Mental Health Review Tribunal, the Regional Visiting Committees and District Visiting Committees have not been established. The Tribunal and Visiting Committees are expected to protect the human rights of clients while the District Mental Health Sub-committees will advise the District Coordinators and organise advocacy campaigns to increase the visibility of mental health in the districts.

There is lack of clarity on the lines of reporting and sources of funding of Regional Mental Health Subcommittees and the Regional Coordinators in relationship to the GHS. The Regional Coordinators are appointed by the MHA to be members of the Regional Health Management Team. This double allegiance of the Regional Coordinators to the Regional Directors of Health Services and MHA has created some organisational inefficiencies.

Delay in passing the Legislative Instrument (LI) to the Mental Health Act constrains the full implementation of the Law. Apart from establishing a mental health levy to provide sustainable funding for mental health operations, the LI will provide legal backing for the admissions of emergency cases and the use of various administrative forms such as the consent form and the certificate of urgency.

2.4.7 Information, Communication and Research

Considerable progress has been made to integrate mental health data into routine health service data. This will provide more reliable information for mental health services planning and delivery. Routine mental health data is captured on the District Health Information Management System (DHIMS). In collaboration with the GHS, the MHA has worked out a set of indicators to evaluate mental health services as part of the holistic assessment of the health sector. Previously aggregated mental health data has been disaggregated thus increasing the mental health conditions routinely reported from four (4) to thirty (30).

The MHA has printed a variety of educational materials for health promotion and public awareness on topics like suicide, depression and epilepsy. It has also organized behavior change and advocacy campaigns on mental health to the general public, healthcare providers, the judiciary and security services on stress management and decriminalization of suicide. This was in the wake of increased media reports of suicides and attempted suicides in 2017 when it became necessary to sensitize the public on suicide awareness and the judiciary against criminalization of attempted suicide. Attempted suicide remains a crime in Ghana's law [Section 57 (2) of the Criminal Offences Act, 1960 (Act 29)].

The MHA recognizes that other agencies delivering mental health care, like GHS, CHAG and the teaching hospitals, and civil society organisations, have such information, education, and behavior change communication materials on various mental health topics. The MHA will coordinate these materials for mutual benefit without having to reinvent the wheel and build on them.

Challenges

There is lack of research on mental health; mental health research accounts for about 0.4% of health publications in Ghana.[34,35] Among the factors for this low rate are the huge workload on the few mental health practitioners, lack of research capacity, lack of interest amongst researchers and lack of funds dedicated to mental health research.

In spite of the progress made in data management, Ghana largely runs a parallel mental health reporting system. The mental health data integration into the DHIMS is ongoing. Providers are yet to be trained on data capturing to fully realise the integration process. Type of data, as well as the quality and consistency of data, are a major challenge. There is also the need for user-friendly terminology in the local languages in the communities, primary care and district services.

2.4.8 Health Technology and Infrastructure

Health technology, as defined by the WHO, is the application of organized knowledge and skills in the form of devices, medicines, vaccines, procedures and systems to solve a health problem and improve quality of lives.[36] Health technology is primarily procured by government or funded through the IGF. However, in 2017-2018 DfID provided equipment and refurbished a ward in each of the three psychiatric hospitals. Due to government's inability to provide adequate psychotropic medicines, some philanthropists and local NGOs notably Breast Care International and BasicNeeds-Ghana, have on several occasions assisted. On other occasions, the psychiatric hospitals have arranged with pharmaceutical companies to supply psychotropic medicines on cost recovery basis to clients or clients have been given prescription forms to purchase out of pocket from private pharmacies.

Challenges

The physical structures of the psychiatric hospitals are old. Accra Psychiatric Hospital is 112 years old, Ankaful Psychiatric Hospital is 53 and Pantang Hospital is 43 years old. The structures of these hospitals have not seen any major renovations since they were constructed. As a result, the existing infrastructure is in serious state of disrepair. A lot of the equipment and medical devices in the hospitals are obsolete.

Transportation is a major challenge at all levels, from MHA headquarters to the facilities, the regions and districts. This has led to inadequate outreach services, monitoring and supervision and has affected service delivery at the lower levels.

The perennial shortage of psychotropic medicines affects quality of care and reduces clients' confidence in allopathic care. This is compounded by the cultural belief in super-natural causes of mental health conditions that has led to many clients seeking traditional and spiritual care. Clients thus present late to the orthodox facilities for proper care.

2.5 Summary of Context

The significance of mental health has increasingly been recognized globally and nationally. Various international agreements, treaties and conventions confirm this. The latest global document, Agenda 2030 of the Sustainable Development Goals specifically mentions mental health. Ghana's national health policy 2020-2030 being developed emphasizes mental health, likewise Ghana's 1992 constitution and other statutes affirm the importance of mental health. Ghana has been making efforts to improve healthcare and outcomes but mental health has not received a corresponding attention with adequate financial, logistics and other resources. Mental health conditions continue to plaque the country with a great burden of disease. There are very few infrastructural services and

human resources mental health care suffers low prioritization, stigma and discrimination. It is in this light that this multi sectoral policy is being developed to tackle the various aspects of mental health care.

Chapter 3: Policy Thrust

3.1 Vision, Mission, Goal and Objectives

Vision: A mentally healthy population

Mission: Contribute to the wellbeing of all people living in Ghana by promoting mental health and involving all sectors of the society through human rights approach

Goal: Improve mental health situation in Ghana, prevent and reduce mental ill-health, disability and preventable deaths associated with mental health conditions across the life span of the individual

Broad Objectives: This policy has five broad Objectives teased out and modified from the five main health sector objectives.

1. Integrate and expand access to quality mental health services, including substance-related disorders, focusing on community level services, identifying risks for, and protective factors against, developing and managing mental illnesses and support;
2. Ensure sustainable financing for mental health service delivery and financial risk protection for people with mental health conditions;
3. Improve efficiency in governance and management of mental health services focusing on human resources, research and Information, Communication and Technology (ICT);
4. Build partnerships with all sectors and harness their resources for mental health services; and
5. Reduce stigma and discrimination against persons with mental health conditions by promoting their human rights.

These broad objectives have been expanded into 12 specific objectives in the mental health sector which are the key policy thrust areas. For each thrust area, a policy objective has been identified, brief strategies are discussed to resolve challenges earlier noted and key results have also been specified:

3.2. Service Delivery

Access to equitable mental health service is enhanced by the integration of mental and physical health services using a human rights oriented approach with a focus on community level services and support, including primary health care. In this policy and elsewhere in mental health care in Ghana, community level mental health care means all mental health services outside the psychiatric hospitals.

Mental health services involve inputs and processes within an organization to achieve mental health outcomes. Services may be promotive, preventive, diagnostic, therapeutic or rehabilitative. Key challenges include inadequate spread of services (over-centralization), over reliance on medications (medicalization), tendency to limit care to long stay services (institutionalization) and inadequate logistics to provide services at all levels. The reality is that the service is limited in terms of coverage and quality.

Policy Objective

The objective is to expand access to a decentralized, integrated, quality and affordable mental health service for Universal Health Coverage.

Strategies

- Support the development of a holistic gender-sensitive, a decentralized and integrated mental health service at all levels including primary health care, and comprising
    i. orthodox, traditional and other alternative providers,
    ii. public and private sectors
    iii. home-based care, community-based and facility services,
    iv. promotive, preventive, diagnostic, therapeutic and rehabilitative services;
- Utilise standards, protocols and guidelines to provide quality mental health services;
- Expand the coverage of mental health services particularly in under-served communities through CHPS;
- Develop specific programmes for improving mental health service delivery across the life span (infants, children, adolescents, adults and the aged) and other sub-groups such as the poor, the vulnerable, persons with substance related disorders, persons with mental health conditions roaming the streets, persons with mental health conditions in the criminal justice system and persons with mental health conditions who have physical disabilities and to integrate maternal mental health care into maternal care and emergency mental health services into general emergency care, and
- Enlist the support and participation of all stakeholders, both public and private, orthodox and unorthodox mental health services towards the realization of the vision of the policy.

Key Results

- All Regional Hospitals have Mental Health Wings of ten (10) to twenty (20) beds;
- Every District Hospital has a mental health unit with five (5) virtual beds in the general wards;
- Every health facility, including CHPS and private facilities, provides mental health services;
- All mental health service providers including traditional and faith-based healers adhere to the minimum standard of care according to national guidelines and protocols;
- No person with mental health conditions found roaming the streets;
- Forensic services including security psychiatric units established, both in the prisons and in the psychiatric hospitals;
- Prison rehabilitation services provided for inmates with substance use addiction, and

- Maternal mental health care integrated into maternal care and emergency mental health services into general emergency care.

3.3. Human Resource Capacity

Human resource capacity challenges including inadequate staffing, training, retention, distribution, right skill mix and poor staff attitude have affected effective mental health delivery over the years. Over concentration of some cadres of human resources at the tertiary level deprives the community of adequate quality service. The policy focuses on human resource production, capacity building, equitable distribution, staff attitude, motivation and retention.

Policy Objective

The policy objective is to build a right resourced, skill-mix and well-motivated workforce for mental health services.

Strategies:

- Map out the existing human resource capacity with projection and establish National Staffing Norms for mental health services while engaging training institutions to train the required numbers and quality for equitable distribution;
- Review the curriculum and build capacity of pre-service training institutions on mental health;
- Motivate staff by providing requisite logistics and conducive working environment while ensuring proper staff attitude;
- Provide Continuous Professional Development programs for staff;
- Mobilize and train other professionals - health and non-health - for early identification of mental health conditions, promotion and maintenance of good mental health;
- Tap the human resource of diasporean Ghanaians through organizing orientation programmes for interested ones; and
- Train and involve traditional and faith-based healers as frontline informal community mental health workers.

Key Results

- National Staffing norms established for mental health services and all facilities and service areas have the right skill mix of staff;
- Every Regional Hospital has at least a member each of the clinical staff (psychiatrist/clinical psychiatric officer, clinical psychologist, psychiatric nurse, social worker and occupational therapist), and other staff as relevant and possible;
- At least 50% of all district hospitals have a member each of the clinical staff (psychiatrist/clinical psychiatric officer, clinical psychologist, psychiatric nurse, social worker and occupational therapist) and other staff as relevant and possible;

- All health centers have at least one psychiatric nurse;
- Every CHPS zone/compound has a Community Mental Health Officer or Community Health Officer trained in mental health;
- 70% of staff motivated based on staff satisfaction survey;
- Employee Assistance Programme established in all MDAs and other workplaces and educational institutions;
- Every mental health personnel has at least one structured CPD every three years; and
- Every mental health related professional curriculum reviewed at least once every five (5) years.
- All traditional and faith-based healers in mental health are trained, regulated and monitored as frontline informal community mental health workers.

3.4. Financing

Mental health service in Ghana is financed primarily by government, complemented with funds from development partners, internally generated funds and philanthropists. The key challenges in this area are inadequate and erratic flow of funds from government and other sources and also lopsided top heavy expenditure of funds at the tertiary level against primary care.

Policy Objective

To ensure sustainable financing of mental health services and equitable distribution of funds.

Strategies:

- Develop a comprehensive plan for domestic and international resource mobilization;
- Ensure adequate investment in infrastructure, psychotropics and financing of mental health services especially in underserved areas;
- Ensure the inclusion of mental health services under the National Health Insurance Scheme;
- Ensure fair and equitable distribution of financial resources towards primary health care in line with WHO's recommended pyramid of care (See Appendix IIII);
- Improve transparency, accountability and efficiency in the utilization of resources;
- Embark on comprehensive costing of services to determine cost per patient per condition and cost of infrastructure;
- Ensure the establishment of the mental health levy called for in the Mental Health Act, 2012 (Act 846);
- Engage and involve the private sector for resource mobilization; and
- Ensure accountability and efficient utilization of resources.

Key Results

- A resource mobilization strategy completed;
- A well-resourced Mental Health Fund operational with clear guidelines of how the money in the Fund is to be disbursed;
- Mental Health Levy established to feed the Fund;
- A minimum of five (5) percent of the health budget allocated to mental health services;
- Mental health services included in national health insurance minimum benefit package;
- Public financial management systems strengthened in all institutions;
- A revolving fund established for the sustainable supply of psychotropic medicines; and
- A costing model for infrastructural development needs of the psychiatric hospitals developed.

3.5. Governance and Partnership

Governance is central to the effective functioning of any health system, including mental health. The governance and partnership arrangements will ensure inclusion of service users in decision making processes, effective stewardship, strengthen regulation, coordinate partners as well as improve management and accountability. The key challenges include the delay in passing the LI and establishing the governance structures within the MHA. Another challenge is little or no collaboration with the private sector and other agencies due to the absence of relevant MoUs between MHA and her partners.

Policy Objective

To achieve effective partnership, leadership, coordination and accountability.

Strategies

- Map out stakeholders including the private sector as partners in mental health;
- Establish governance structures that will deepen the collaboration between the Mental Health Authority, key partners and other stakeholders in mental health care;
- Train functionaries of mental health governance structures to achieve set objectives;
- Ensure effective decentralization of mental health services;
- Provide a framework to monitor performance and promote accountability;
- Engage development partners to invest in mental health;
- Strengthen policy dialogue and establish effective inter-sectoral collaboration with all MDAs and partners;
- Create a conducive regulatory environment for promoting mental health services; and
- Ensure that all governance structures in the Mental Health Act, 2012 (Act 846) are established and effectively operational while strengthening leadership at all levels and including service users on these decision making bodies.

Key Results

- Legislative Instrument (LI) to Mental Health Act, 2012 (Act 846) passed;

- Appointments of senior staff of MHA completed;
- Mental Health Review Tribunal established;
- Visiting Committees established at the regional levels;
- District Mental Health Sub-Committees established and Coordinators appointed;
- Mental health integrated into existing inter-sectoral coordinating mechanisms at the district, regional and national levels;
- Mental health integrated into existing peer review mechanisms of Ministry of Health and partners;
- MoU with Ghana Health Service, other agencies and partners signed;
- A stakeholder mapping of actors in mental health available;
- Effective internal control systems for accountability established.

3.6. Health Technology and Infrastructure

Health Technology is an essential component of service delivery and impacts on quality of care. It encompasses ICT, equipment, medical commodities, transport and other essential logistics. The deployment of health technology will be guided by existing policies on supply chain. Among the key challenges are non-availability of psychotropic medicines and obsolete equipment. Infrastructure is another major issue which requires attention for proper and quality mental health service.

Policy Objective

Provide appropriate health technology and infrastructure for the delivery of mental health services.

Strategies

- Establish standards for the design and structure of mental health wings;
- Establish a small psychiatric hospital in each of the northern and middle belts of the country;
- Improve information and communication technology infrastructure in mental health and build staff capacity in ICT;
- Provide adequate and appropriate means of transportation at the various levels of care
  Ensure that mental health facilities are disability friendly, including providing for interpreters and signers;
- Collaborate with GHS and other service delivery agencies to design and incorporate mental health units in those facilities;
- Deploy ICT in all mental health facilities.
- Incorporate e-health and tele-psychiatry in mental health care especially in under-served areas.

Key Results

- Two 40-50 bed capacity psychiatric hospitals constructed, one each in the northern and middle belts;

- Existing psychiatric hospitals downsized and refurbished to standard;
- Guidelines developed for the establishment of psychiatric wings within existing regional hospitals;
- All mental health services digitized on e-health platform;
- Adequate and appropriate transport services available at all levels;
- Mental health facilities are disability friendly with sign language interpreters; and
- Local production of supplies, including pharmaceuticals for the national and regional stores supported; and
- Mental health services available through tele-psychiatry in under-served areas.

3.7. Human Rights

According to Article 1 of the Universal Declaration of Human Rights, "All human beings are born free and equal in dignity and rights."[37] One of the greatest challenges of Mental Health Service in Ghana is in the area of human rights abuse yet the UN Convention on the Rights of Persons with Disability (CRPD) enjoins on all member states to respect and promote the rights of such persons. These include persons with mental health conditions who are particularly vulnerable and it behoves the country to protect them from discrimination and abuse. This policy aims at ensuring, protecting and promoting the human rights of persons with mental health conditions in all social settings.

Policy Objective

To implement strategies to protect and promote the human rights of people with mental health conditions.

Strategies

- Guarantee the rights of persons with mental health conditions at all levels including ensuring their representation (by themselves or their carers) on decision making bodies, implementation and monitoring processes;
- Strengthen the Mental Health Review Tribunal and Visiting Committees for human rights protection;
- Collaborate with the Ministries, Departments and Agencies, NGOs, Traditional Rulers and Civil Society to protect the human rights of persons with mental health conditions;
- Engage prayer camps and other faith based healers to respect the rights of persons with mental health conditions under their care including the abolition of chaining;
- Engage the legislature and judiciary to review the statutes to expunge stigmatizing words and decriminalize, attempted suicide and other mental health related conditions;
- Embark on public education on human rights abuses;
- Conduct training of health professionals, non-health professionals and the general public on human rights and ensure compliance with appropriate sanctions against any contravention; and
- Implement guidelines for engagement of traditional and faith based healers.

Key Results

- Existing legislations that perpetuate stigma, discrimination and human rights violations repealed or amended;
- Stigmatizing words like 'imbecile', 'idiot' and 'lunatics' referring to persons with mental health conditions expunged from the law books;
- Visiting committees strengthened in all the regions;
- Mental Health Tribunal strengthened;
- Banning of all forms of human rights abuses (e.g. chaining, shackling, caging) enforced; and
- Civil rights of persons with mental health conditions promoted, protected and respected.

3.8. Health Information Systems

Health systems governance throughout the world depends on the availability of quality, relevant and timely information and knowledge. Health information provides the support for evidence-based decision making at all levels of health care. Particularly in a resource-limited country like Ghana, health information is important for prudent resource allocation to reduce wastage and increase efficiency. Key challenge is the absence of reliable database on mental health conditions, risk factors as well as the coverage and quality of services.

Policy Objective

To promote the generation and use of evidence for decision-making.

Strategies

- Improve data management system for effective decision and planning, monitoring and evaluation;
- Define core mental health indicators for monitoring performance;
- Ensure mental health data is part of DHIMS; and
- Establish one-stop-shop for mental health information at the Mental Health Authority Headquarters.

Key Results

- Tele-psychiatry developed and deployed in all mental health facilities and service areas especially in inaccessible areas;
- Diagnostic system standardized at both service delivery points and training institutions;
- Mental health data fully integrated into DHIMS and other relevant information management systems;
- Information and data linked nationwide through Wide Area Network; and
- Core mental health indicators produced for holistic assessment of the Health Sector.

3.9. Research and Publications

Research is very crucial for evidence-based decision making as well as policy development and review. The key challenge is the paucity of research and publication on mental health. There is a need for continuous quantitative and qualitative research and dissemination of information to generate feedback and inform policy direction.

Policy Objective

To establish a mental health research agenda, build capacity, mobilize funding and embark on research and publication.

Strategies

- Encourage research on mental health;
- Build the capacity of relevant institutions and individuals for mental health research;
- Raise adequate funds for mental health research and publication; and
- Organize forums for dissemination of research findings;
- Develop research agenda, build capacity and provide incentives for mental health research and publication.

Key Results

- Research agenda developed for mental health;
- A functioning research department established within the MHA;
- At least ten percent (10%) of any mental health funding goes into research;
- At least five percent (5%) of all health research publications from Ghana in peer review journals are on mental health;
- Annual national scientific forum on mental health organized to share research findings;
- A scientific journal dedicated to research findings on mental health established in the country and operational; and
- Database of mental health research in Ghana established.

3.10. Abuse of Alcohol and Other Substances

The abuse of alcohol and other substances has been widespread across the country. Currently there is the emergence of the use of *Shisha*[38] and abuse of tramadol[39] as a threat to public health. Although there is a national alcohol policy[40], this is yet to be disseminated and implemented. Since the enactment of the Tobacco Law [Section VI of the Public Health Act, 2009 (Act 852)], tobacco use has declined though it remains a problem. The narcotics policy of the Narcotics Control Board emphasizes more on criminalization than prevention and treatment.

Policy Objective

To prevent/minimize harm associated with substance use including alcohol abuse and advocate for the decriminalization of addiction.

Strategies

- Establish epidemiological, behavioral and anthropological data on substance- related disorders;
- Develop guidelines and provide services for the treatment and rehabilitation of persons with substance use disorders;
- Engage the criminal justice system to recognize addiction to substances as a disease and refer persons with substance use problems to the health system;
- Engage training institutions to include the management of substance-related disorders in their curriculum;
- Establish links with schools, youth centers and work places for referral pathways;
- Increase public education on the dangers of substance use;
- Train addiction professionals; and
- Liaise with appropriate bodies for enforcement of tobacco law, alcohol policy and narcotic law;
- Engage stakeholders towards the development of research and policy guidelines;
- Collaborate with FDA, NACOB, GHS and GES for public education against substance abuse;
- Collaborate with the legislature and the criminal justice system towards decriminalization of addiction;
- Establish drug rehabilitation centres to treat persons with addiction problems; and
- Establish Addiction Profession as a career for addiction management issues.

Key Results

- Services for treatment of substance use disorders (detoxification, counselling, medication, rehabilitation) provided;
- At least three public rehabilitation centres established in the northern, middle and southern zones of the country;
- Guidelines for care and rehabilitation developed;
- Substance use integrated into the curriculum of pre-service health training institutions;
- Epidemiological, behavioral and anthropological data on substance use and related disorders available and substance use observatory established;
- Referral pathways for schools, youth centers, work places established; and
- Tobacco law, alcohol policy and narcotic law effectively enforced and compliance monitored;
- Addiction Profession career established; and

- Public education on substance use intensified.
- Existing laws that tend to criminalize possession and use of narcotic substances by persons addicted to these drugs amended;

3.11. Suicide and Suicide Prevention

Suicide is a worldwide problem which leads to 800,000 deaths every year.[41] Suicide is highly correlated with mental health problems.[42] Over 90% of attempted or completed suicides have mental health conditions,[43] mostly depression. In Ghana, there are periodic media reports of surges with the latest surge in 2017 when sixteen deaths were reported in the media in the first quarter while thousands contemplated suicide in the same period. Suicidal behavior is considered immoral and a taboo, and is stigmatized in many cultures. It is also considered as a sin by the religious community and a crime by the laws of the country [Section 57(2) of the Criminal Offences Act, 1960 (Act 29)].

Generally, the nature and dynamics of suicide is little understood by the public. There is neither a national policy nor emergency service for suicidal behaviour. This policy outlines the framework of managing suicidal behaviours.

Policy Objective

To reduce the incidence of suicide and attempted suicides by creating general awareness and providing services for suicidal behaviour.

Strategies

- Establish epidemiological, behavioral and anthropological data on the nature of suicidal behaviours;
- Develop a national policy for suicide and suicide prevention;
- Educate the general public on the nature of suicide;
- Establish suicide emergency services including suicide response teams and toll-free helplines;
- Offer training on suicide prevention management to health institutions, schools, workplaces and the general public;
- Train the police and the judiciary to recognize suicidal behaviour as a mental health condition;
- Advocate for the repeal of section 57(2) of the Criminal Offences Act, 1960 (Act 29) to decriminalize suicidal behaviours;
- Embark on public education on suicide; and
- Engage the legislature and the criminal justice system towards decriminalization of suicidal behavior.

Key Results

- National policy and guidelines for suicide and suicide prevention developed;
- Epidemiological, behavioural and anthropological data on suicidal behaviours available;
- General awareness created using evidence-based behaviour change strategies;
- Health personnel can identify and manage suicidal behaviours;
- The police and the judiciary can recognize suicidal behaviours as a medical condition and make appropriate referrals for services;
- Section 57(2) of the Criminal Offences Act, 1960 (Act 29) amended to decriminalize suicidal behaviours;
- Emergency suicide intervention teams and toll-free help lines in place; and
- Suicide coded on Death Certificate as a cause of death.

3.12. Mental Health Promotion

Many mental health conditions can be prevented through knowledge of their causes, avoidance of trigger factors and acquisition of first aid skills. Their early identification and prompt treatment can lead to improved outcomes.

Mental health promotion can lead to mental well-being, build resilience and reduce preventable deaths. The key challenge is that there is a pervasive lack of knowledge about the nature and causes of mental health conditions across the life span contributing to the stigma and discrimination.

This policy outlines measures to promote mental health and reduce stigma and discrimination. It also provides guidelines for the prevention of mental health conditions and their early identification for effective treatment. These measures consider life span conditions and different groups and settings like educational institutions and organizational work places.

Policy Objective

To create general awareness of mental health, build resilience to cope with the daily stresses of life, promote mental health self-care and improve help-seeking behaviour.

Strategies

- Develop tailored educational programmes on mental health targeting specific groups and settings;
- Educate the general public on the nature and causes of mental health conditions across life span, the rights of persons with these conditions, coping mechanisms and self-care and the need to seek early help;
- Promote the role of household, communities, work places, educational institutions and religious bodies as major stakeholders in the promotion of mental health; and
- Include mental health awareness programmes in curricula of schools and colleges.

Key Results

- Relevant educational materials on mental health developed;
- Appropriate behaviour change communication messages targeted at specific groups;
- The general public has relevant coping and self-care skills;
- Improved mental health understanding as demonstrated in surveys;
- Persons with mental health conditions fully integrated into the community; and
- Mental health awareness programmes included in curricula of schools and colleges.

3.13 Poverty and Vulnerability

Generally, poverty can contribute to the cause and outcome of mental health conditions; and mental health conditions do contribute to poverty. Children, the youth, women, the aged, the disabled and persons with mental health conditions, amongst others, tend to be vulnerable and this vulnerability has negative effect on their mental wellbeing The key challenge is that these identifiable groups of people do not have adequate protection for their mental health care needs. This policy addresses the issue of poverty and vulnerability adversely affecting mental wellbeing.

Policy Objective

To provide quality care and sustainable livelihood for the poor and vulnerable and provide financial risk protection for the vulnerable.

Strategies

- Engage relevant agencies to identify the poor and vulnerable;
- Create a platform to enroll the poor and vulnerable in existing pro-poor social intervention programmes;
- Support poor and vulnerable persons with mental health conditions for continuous care and independent living;
- Target mental health promotion programs towards the vulnerable persons and advocate for support to them;
- Engage with the relevant MDAs to provide livelihood support and other government social interventions, like LEAP and the disability fund, for the poor and vulnerable persons with mental health conditions; and
- Engage the relevant MDAs to identify vulnerable persons for targeted education.

Key Results

- At least 80 Percent of persons with mental disorders benefitting from government social intervention programmes (LEAP, MASLOC, NHIS, DACF etc.);

Chapter 4: Implementation Framework

Attaining and maintaining good mental health as conceived in this policy framework extends beyond the purview of the MoH and the MHA. Other MDAs and private organisations have a major role to play towards the achievement of the goal and vision of this policy. The MoH will provide the leadership in mobilizing support from all players. The MoH will also build partnership with other MDAs, civil society and the private sector for mental health development.

The detailed specific roles of the MDAs will be spelt out in the stakeholder mapping to be developed in due course. Below, however, is a summary of responsibilities of some of the key MDAs:

A. The Ministry of Health and Its Agencies

The Ministry of Health, together with its Agencies, will oversee the formulation of health service policies, mobilization of resources, provision of health services, coordination and regulation of health service delivery.

B. Other Ministries, Departments and Agencies (MDAs)

Other MDAs will be key to the implementation of this policy. These include:

i. MDAs Responsible for Planning, Monitoring and Evaluation

The National Development Planning Commission (NDPC) is responsible for macro planning at the national level. It has the responsibility to monitor, evaluate and co-ordinate policies, programmes and projects, among other functions. It will work with the Ministry of Health to set overall policy goals and targets that will help to achieve the goals set in this policy. The NDPC and the Ministry responsible for Monitoring and Evaluation, shall monitor the attainment of the goals and targets.

ii. MDAs Responsible for Human Rights and Good Governance

These include the Attorney-General's Department, the Police, the Judiciary, the Auditor-General, Parliament, the Public Procurement Authority and its responsible Ministry, and the Commission on Human Rights and Administrative Justice (CHRAJ). These agencies protect human rights and prohibit discrimination in any form. The Mental Health Authority, through the Ministry of Health, will collaborate with these MDAs to develop and monitor the policies and programmes set out in this document to ensure good governance and protect the rights of persons with mental health conditions.

iii. MDAs Responsible for Finance

These MDAs include the Ministry of Finance, the Controller and Accountant-General's Department and the Financial and Banking Institutions. The Mental Health Authority will collaborate with these MDAs to mobilize resources for promoting and maintaining good mental health.

iv. MDAs Responsible for Social Services and Protection of the Vulnerable

Access to social services by all citizens is guaranteed by the Directive Principles of State Policy in Chapter Six of the 1992 Constitution of Ghana and underpins the central motive of the Mental Health Policy. The welfare of the vulnerable groups and the creation of opportunities for the disadvantaged are also seen as fundamental human rights. Social sector services including the Ministry of Gender,

Children and Social Protection, Department of Social Welfare, Ministry of Youth and Sports are key to the realization of the objectives set out in this policy.

v. MDAs Responsible for Civic Education, Culture and Religious Affairs

These MDAs include the Ministry of Chieftaincy and Religious Affairs as well as Tourism, Arts and Culture, Ministry of Communication, Department of Information Services, National Commission for Civic Education (NCCE) and the National Media Commission. The roles of these MDAs include the promotion of cultural and religious values, civic education and the understanding of the causation of mental conditions and help-seeking behaviour of people with mental health conditions.

vi. MDAs Responsible for Education and Training

These MDAs include the Ministry of Education, Ghana Education Service and Tertiary Training Institutions such as the Medical Schools and the Teaching Hospitals. Included here are also private health and education training institutions. These MDAs and institutions have a key role in developing human resource but also in human development per se, especially during early childhood. They are involved in early identification of symptoms, stigma reduction and provision of counseling services.

vii. MDAs Responsible for Decentralization

The Ministry of Local Government and Rural Development (MLGRD) is responsible for the decentralization of the governance structures in the country. It creates and oversees regional, municipal and district administration of the government through the MMDAs, the regional coordinating councils and district assemblies. The MLGRG will have the role of linking up with the decentralization policy of the MHA.

At the MMDA's level, health services are coordinated by the leadership of the MMDAs through the social sector sub-committee and most of the mental health issues can be addressed through this window. Most of the social intervention programmes at their level are coordinated by Metropolitan, Municipal and District Chief Executives.

viii. **Agencies Responsible for Service Delivery**

These agencies include Ghana Health Service, Teaching Hospitals, Quasi Government, and faith-based organizations such as CHAG and Ahmadiyya Muslim Mission Ghana and private facilities and services, both for-profit and not-for-profit entities. These agencies provide in-patient, out-patient, rehabilitation and outreach and mobile services in their catchment areas.

ix. Organisations Responsible for Advocacy and Community Engagement

These organisations include CSOs and NGOs. They are involved in creating awareness, advocacy and mobilizing community groups for mental health action.

x. Development Partners Responsible for External Resource Mobilisation and Technical Support

Development partners include bilateral organisations such as DfID and multilateral organisations such as WHO. They play key roles like international and national advocacy, technical support and in mobilizing external resource for mental health services. They also set international standards for

health and mental health practice. Partnership arrangement for the implementation of this policy will be supported by strengthening the relationship with development partners.

xi. The Role of the Community, Civil Society, CSOs, Traditional and Faith Based Healers

The community and civil society at large have a major role. Civil Society Organisations (CSOs) like NGOs have a big role to play in mental health care in Ghana and in the full implementation of this policy. Already they have been playing a key role and can play further. While they are mostly involved in awareness creation, some are engaged in ensuring that human rights of clients are respected and others involved in community building, community mobilization and serving as frontline informal community mental health workforce. Some of these NGOs, like BasicNeeds-Ghana, actually engage in indirect service delivery through facilitation of specialist outreach services to underserved areas, training and provision of sustainable means of livelihood for the vulnerable. The policy recognizes these roles and intends to strengthen and further enhance the roles.

Traditional and Faith-Based healers play a role in mental health care and are key to the success of the policy implementation. These healers are often the first point of call in the help-seeking pathway. The policy intends to rope them in as frontline informal community mental health workers for mental health promotion and mental health first aid.

Chapter 5: Monitoring, Evaluation and Communication Plan

This policy document will be disseminated through the following communication channels: workshops, conferences, durbars, seminars, school talks, public meetings, health facilities, MDAs, MMDAs, parliament, faith based organizations, private health facilities, health training schools at all levels, the churches and mosques.

This policy will be implemented through the accompanying Strategic Plans which shall be developed. The detailed implementation of this policy through the accompanying strategic plans shall be monitored continuously to determine how much progress is being made towards the attainment of the stated policy objectives.

Reporting of activities will be done through various channels. Data on service, protocols, guides, registers and forms will be reported through DHIMS. Other bits of information will be reported through routine quarterly, semi-annual and annual reports ultimately to the Minister. Other means of reporting and communication shall include newsletters, media dissemination and other channels earlier outlined in this chapter.

The MoH will coordinate the monitoring of mental health policy implementation and services at all levels. Monitoring of the progress and achievement of the health outcomes will be routine on a quarterly, half-yearly and annual basis, and will focus on determining the extent to which planned activities are being achieved. As part of the holistic assessment of the health sector a set of indicators and targets as well as tools for data capture and reporting will be developed in a strategic plan in collaboration with stakeholders.

Surveys shall be done to complement routine data. These shall include staff and client satisfaction surveys. Behavioural surveys may be done to better understand the personal and environmental factors that contribute to mental health.

To a large extent, the principle of peer review will be applied in the assessment of the implementation of the policy. Independent reviews will be done within the planned period to determine the progress made in the implementation of the policy.

Evaluation of the success of the implementation of the Policy shall be done at the end of four years (short-term), eight years (medium term) and twelve years (long-term). Evaluations shall be conducted based on an agreed framework with the implementing partners.

Reporting and feedback will be communicated through the same channel described above.

Appendices

Appendix 1: Policy Implementation Schedule

MENTAL HEALTH POLICY														
			SHORT TERM				**MEDIUM TERM**				**LONG TERM**			
No.	**POLICY**	**KEY RESULTS**	**2019**	**2020**	**2021**	**2021**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
		1. All Regional Hospitals have Mental Health Wings of ten (10) to twenty (20) beds												
		2. Every District Hospital has a mental health unit with five (5) virtual beds in the general wards												
		3. Every health facility, including CHPS and private facilities, provides mental health services												

	Service Delivery	4. All Orthodox Mental Health Service providers adhere to minimum standard of care according to the national guidelines and protocols												
		5. No person with mental health condition found roaming the street												
		6. Forensic services including security units established both in prisons and the psychiatry hospitals												

4.3		7. Prison rehabilitation services provided for inmates with substance addiction												
4.4	**Human Resource Capacity**	1. National Staffing norms established for mental health services and all facilities and service areas have the right skill mix of staff												
		2. Every Regional Hospital has at least a member each of the core clinical staff (psychiatrist/clinical psychiatric officer, clinical psychologist, psychiatric nurse, social worker and occupational therapist) and other staff as relevant and possible)												

		3. At least 50% of all district hospitals have a member each of the core clinical staff (psychiatrist/clinical psychiatric officer, clinical psychologist, psychiatric nurse, social worker and occupational therapist)												
		4. All health centers have at least one psychiatric nurse												
		5. Every CHPS zone/compound has a Community Mental Health Officer or Community Health Officer trained in mental health												

		6. 70% of staff motivated evidenced from staff satisfaction survey												
		7. Employee Assistance Programme established in all MDAs and other workplaces and educational institutions												
		8. Every mental health worker has at least one structured CPD every three years												
		9. Every mental health related professional curriculum reviewed at least once every five (5) years												
4.5	**Financing**	**1.** A resource mobilization strategy completed												
		2. A well-resourced mental health Fund operational with clear guidelines of how the Fund is to be distributed												
		3. Mental Health Levy established to feed the Fund												

		4. A minimum of five (5) percent of the health budget allocated to mental health services											
		5. Mental health services included in national health insurance minimum benefit package											
		6. Public financial management systems strengthened in all institutions at all levels											

		7. A revolving fund established for the sustainable supply of psychotropic medicines												
		8. A costing model for infrastructural development needs of the mental health facilities developed												
		1. Legislative Instrument (LI) to Mental Health Act, 2012 (Act 846) passed												
		2. Appointments of senior staff of MHA completed												
		3. Mental Health Review Tribunal established												
		4. Visiting Committees established at the regional levels												
		5. District Mental Health Sub-Committees established and Coordinators appointed												

	Governance and Partnership	6. Mental health integrated into existing inter-sectoral coordinating mechanisms at the district, regional and national levels												
		7. Mental health integrated into existing peer review mechanisms of Ministry of Health and partners												
		8. MoU with Ghana Health Service, other agencies and partners signed												

4.6		9. A stakeholder mapping of actors in mental health available												
	Health Care Technology	1. Two 40-50 bed capacity psychiatric hospitals constructed, one each in the northern and middle belts												
		2. Existing psychiatric hospitals downsized and refurbished to standard												
		3. Guidelines developed for the establishment of psychiatric wings within existing regional hospitals												
		4. Allmental health services digitalized												
		5. All mental health facilities are disability friendly including providing for interpreters and signers												
		6. Adequate and appropriate transport services available at all levels												

		7. Local production of supplies, including pharmaceuticals for the national and regional stores supported.														
		1. Existing legislations that perpetuate stigma, discrimination and human rights violations repealed or amended														

4.8	**Human Rights**	2. Stigmatizing words like 'imbecile', 'idiot' and lunatics referring to persons with mental health conditions expunge from the law books												
		3. Visiting committees strengthened in all the regions												
		4. Mental Health Tribunal strengthened												
		5. Banning of all forms of human rights abuses (e.g. chaining, shackling, caging) enforced												
		6. Human rights of persons with mental health conditions promoted, defended and respected												
		7. Quality Rights processes incorporated in mental health care												
		1.Tele-psychiatry developed and deployed in all mental health facilities especially in inaccessible areas												

4.9	**Health Information Systems**	2. Diagnostic system standardized at both service delivery points and training institutions												
		3.Mental health data fully integrated into DHIMS and other relevant information management systems												
		4. Information and data linked nationwide through Wide Area Network												
		5. Core mental health indicators produced for holistic assessment of the Health Sector												

4.10	**Research and Publications**	1. Research agenda developed for mental health												
		2. A functioning research department established within the MHA												
		3. At least ten percent (10%) of any mental health funding goes into research												
		4. At least five percent (5%) of all health research publications in peer review journals are on mental health												
		5. Annual national scientific forum on mental health organized to share scientific Findings												
		6. A journal dedicated to research findings on mental health established in the country and operational												

		7. WHO-AIMS surveyed carried out												
		7. Database on mental health research in Ghana												
		1. Services for treatment for substance use disorders (detoxification, counselling, medication, rehabilitation) provided												
		2. At least three public rehabilitation centres established in the northern, middle and southern zones of the country												

	Abuse of Alcohol and other substances	3. Guidelines for care and rehabilitation developed												
		4. Existing laws that tend to criminalize addiction repealed												
		5. Substance use studies strengthened in the curriculum of pre-service health training institutions												
		6. Epidemiological, behavioural and anthropological data on substance related disorders available and substance use observatory established												
		7. Referral pathways for schools, youth centers, work places established												
		8. Addiction Profession career established for Substance Use Disorders (SUD) treatment and counselling within the Ministry of Health and addiction professionals trained												
		9 Public education on substance use intensified												

		10. Tobacco law, alcohol policy and narcotic law effectively enforced and compliance monitored													
4.11	**Suicide and Suicide Prevention**	1. A national policy and guidelines for suicide and suicide prevention developed													

		2. Epidemiological, behavioural and anthropological data on suicidal behavior available												
		3. General awareness created using evidence-based behaviour change strategies												
		4. Health personnel trained toidentify and manage suicidal behaviours												
4.12		5. The police and the judiciary can recognize suicidal behaviours as a medical condition and make appropriate referrals for services												
		6. Section 57(2) of the Criminal Offenses Act, 1960 (Act 29) repealed to decriminalize suicidal behaviours												

		7. Emergency suicide intervention teams and toll-free help lines in place												
		8. Suicide coded on Death Certificate as a cause of death												
	Mental Health Promotion	1. Relevant educational materials on mental health developed												
		2.Appropriate behavior change communication messages targeted at specific groups												

		3. The general public has relevant coping and self-care skills;												
		4. Improved mental health understanding as demonstrated in surveys												
		5. Mental health awareness programme included in curricula of schools and colleges												
4.13		6. Persons with mental health conditions fully integrated into the community												
4.14	**Poverty and Vulnerability**	1. At least 80 Percent of persons with mental disorders benefitting from government social intervention programme (LEAP, MASLOC, NHIS, DACF etc.)												

Appendix II

Policy Development Process

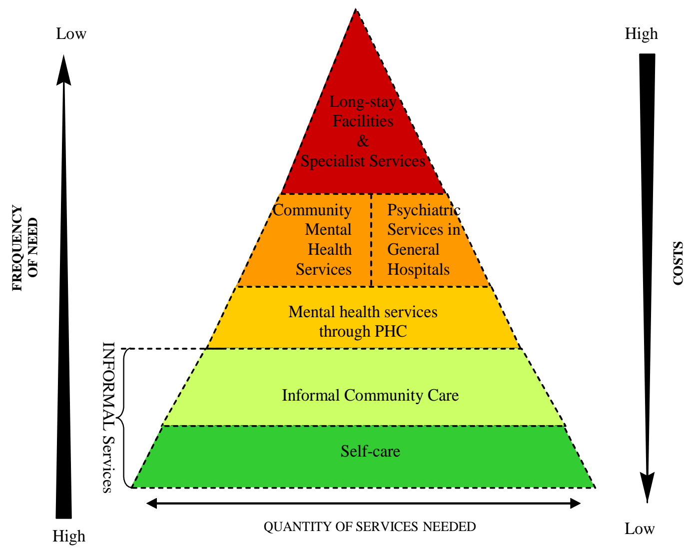
The following groups were interviewed by the OPM consultants during the preparation of the situational analysis from which this policy was crafted:

- ***A total of 66 users and carers*** across the country.
- ***NGOs*** consulted were BasicNeeds Ghana, Mental Health and Well-being Foundation and Mehsog.
- ***Government Ministries* and Departments:** the Ministries of Health; Education; Justice and the Attorney General; the Interior (Police, Prisons); Tourism, Arts and Culture; Gender, Children and Social Protection; Finance**.** The team met two Ministers (Health and Finance).
- ***Agencies:*** Ghana Health Service, CHAG, Nurses and Midwives Council, Narcotics Control Board, Traditional and Alternative Medicine Practice Council, Traditional and Alternative Practice Directorate.
- ***Regional Directors of Health Service***: Ashanti, Brong-Ahafo, Western, Central, Greater Accra, Volta, Eastern, Upper East, Upper West and Northern Regions.
- ***Professional groups:*** Medical Directors of five Regional Hospitals, Medical Superintendent of a District Hospital, 10 Regional Mental Health Coordinators, 12 CPNs, four (4) other mental health workers, two (2) hospital administrators, three (3) psychiatrists, one (1) clinical psychologist, two (2) pharmacists and seven (7) traditional healers.
- ***Health service facilities*** visited: National psychiatric hospitals, Teaching Hospitals, Regional Hospitals, District Hospitals, Polyclinics and health centres and CHPS compounds.

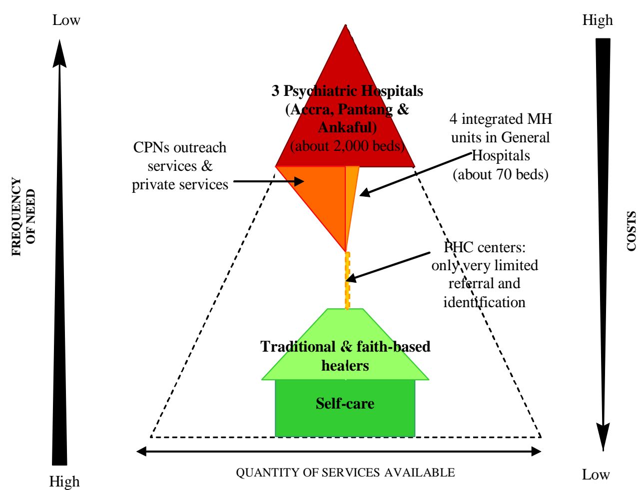
The Situational Analysis Report was widely reviewed. Among the reviewers were the WHO Regional Office at Brazzaville and Country Office in Accra.

MHA consultant carved out the draft policy report from the Situational Analysis Report. Series of stakeholder meetings were held to discuss the draft policy with smaller meetings in between to input the corrections. Finally a big stakeholder meeting of 70 participants drawn from across all sectors validated the policy. This was then sent to the NPDC, Attorney-General and the Ministry of Finance for validation and thence to the MoH for their endorsement.

Appendix III



WHO Pyramid of Optimal Mental Health Services



The reality of virtual inverted pyramid of care

for Ghana (WHO AIMS Ghana 2007)

Appendix IV

List of individuals and their organizations involved in the policy development in diverse ways at various times

Hon. Kwaku Agyeman-Manu (MP)	Minister of Health
Dr. Afisa Zacharia	Former Chief Director, MoH
Nana Kwabena Agyei-Mensah	Ag Chief Director, MoH
Dr. Emmanuel Odame	Director PPME, MoH
Professor Rachel Jenkins (Team Leader)	OPM Consultant
Mr. Lance Montia	OPM Consultant
Dr. Gilbert Buckle	OPM Consultant
Professor Patrick Geoghegan	OPM Consultant
Nick Bain	OPM Consultant
Aaron Adarkwah	Ghana Education Service
Afful Godswill	MHA
Alex Moffat	MOH/PPME/PAU
Alice Amekudzi	NDPC
Amina Bukari	DDNS (retired)
Aminu Zuleiha	MOH- PPME
Anaba Sunday Atua	BasicNeeds
Ansong Dorcas	MHA
Beatrice Amemasor	MHA
Beatrice Nyarko	DDNS – APH
Bernard Akumiah	MEHSOG
Can-Tamakloe Evelyn	MHA
Comfort S. Gyamfi	NMC

Courage Q. Ashiagber	Tamale Teaching Hospital
Dan Taylor	Mind Freedom Ghana
Daniel Osei	Director-General’s Representative, GHS
David Larbi	Nursing Officer, Psychiatry
Davis Otuo Serebour	DDPS, Ankaful Psychiatric Hospital
De Vormatu-Dzeln	Ministry of the Interior
Dr. Akwasi Osei	Chief Executive, MHA
Dr. Amma Boadu	Psychiatrist, APH
Dr. Anna Puklo-Dzadey	Consultant Psychiatrist
Dr. B. K. Wozuame	37 Military Hospital
Dr. Caroline Amissah	Dep. CE, MHA
Dr. Cynthia Sottie	Ghana Health Service
Dr. Delali Fiagbe	Korle Bu Teaching Hospital
Dr. Eugene Dordoye	Ankaful Psychiatric Hospital
Dr. Frank Bening	Pantang Hospital
Dr. Francis Oppong	KATH
Dr. Isaac Annan	CHRAJ
Dr. James Duah	Dep. Executive Director, CHAG
Dr. Kobina Atta Bainson	DFID
Dr. Pinaman Appau	Hospital Director, APH
Dr. Sally-Ann Ohene	WHO
Dr. Sammy Ohene	Consultant Psychiatrist, UGSMD/KBTH/APH
Dr. Titus Beyuo	GMA
DSP (DR) L. K. Acheampong	Ghana Prisons Service

Edward Bruce-Lyle	NDPC
Efua Cofie	MHA
Enoch Ofi Agyekum	JICA
Erica Dickson	Ghana Psychology Association
Felix Logah	Ministry of Gender
Fidelicia Bakobie	MHA/APH
Florence A. Darko	NMC
Frederick Nsatimba	NTC Pantang
Gabriel King Akyah	Ghana Mental Health Association
Georgina Benyah	CHAG
Gifty Clottey	MHA
Godlove Vanden-Bossche	NACOB
Harriet Agyei-Asare	Ministry of Education
Hon. Dr. K. Twum-Nuama	Parliamentary Select Committee on Health
Jagdish Welbeck	MHA
Jenniifer K. Akuamoah	Friends of Mental Health
Joana Abakalo Yamoah	MELR
Emmanuel Owusu-Ansah	MHA Consultant
Humphrey Kofie	MEHSOG
Joseph B. Brako	NTC Pantang
Joseph Laryea	Ministry of Finance
Kwaku Asenso Brobbey	MHA
Kwamena Dadzie-Doneea	NCPD
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Seth Agblemor	MHA
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Priscilla E. Tawiah	MHA
Amina Zuleiha	MOH/PPME
Dorcas Ansong	MHA
Serwaa Gyamfi	MOH
Fidelicia Bakobie	MHA
Munira Malik	MHA
Nana B. Morson	NTC- Pantang
Odame Ball	Mental Health Foundation
Owusu Yankyera	TMPC
Patience Fosu-Peters	MHA
Patience N. Nortey	NTC Pantang
Seyram Avotri	Mental Health Foundation
Simon K. Dogedoung	Ag. Principal NTC
Sylvia Sefa-Roanaa	Office of the Attorney General
Franklin Sarfo	MHA

Appendix IV

WHO pyramid of care

References

[1] Institute of Medicine (2001), *Neurological, psychiatric, and developmental disorders: Meeting the challenge*. Washington: Institute of Medicine

[2] Kessler, R., & Ustun, T. (eds.) (2008) *The World Health Organisation World Mental Health Surveys: Global Perspectives on the Epidemiology of Mental Disorders.* New York: Cambridge University Press

[3] World Health Organisation (2001), *The World Health Report 2001 - Mental Health: New Understanding, New Hope* (Geneva: World Health Organisation): http://www.who.int/whr/2001/en/;

[4] Ofori-Atta A, Reed U, Lund C. A situation analysis of mental health services and legislation in Ghana: Challenges for transformation. African Journal of Psychiatry. 2010;13:99–108. [PubMed]

[5] Maureen E Canavan, Heather L Sipsma, Achyuta Adhvaryu, Angela Ofori-Atta, Helen Jack, Christopher Udry, Isaac Osei-Akoto, and Elizabeth H Bradley. Psychological distress in Ghana: associations with employment and lost productivity. *Int J Ment Health Syst*. 2013; 7: 9. Published online 2013 Mar 7.

[6] Akwasi Osei: Towards a Modern Mental Health Care: The Journey, The Vision. Bayuti Enterprise, March 2016

[7] ibid

[8] Osei AO, Asare JB, and Roberts M, 2018, Brief History of Mental Health Care in Ghana (unpublished).

[9] Ordinance of Gold Coast: The Lunatic Asylum Ordinance of 1888, Cap 79.

[10] Ministry of Health: Mental Health Strategic Plan, September 2014

[11] Oxford University Psychiatrists,www.ox.ac.uk/news/2014-05-23, accessed 24th March 2018);

[12] Harris, E., & Barraclough, B. (1998), Excess Mortality of Mental Disorder, *British Journal of Psychiatry*, 173: 11-53.

[13] Life span approach means the approach that takes care of all ages in the lifespan, from infants through childhood, adolescence, adulthood to old age.

[14] World Health Organisation. who.int/gb/ebwha/pdf_files/WHA66/A66 (Accessed 30 March, 2018).

[15] "Coordinated Programme of Economic and Social Development Policies 2017-2024", presented by the President of the Republic of Ghana to the 7th Parliament of the 4th Republic of Ghana on 20th October, 2017

[16] Ghana Statistical Service (2012). 2010 Population and Housing Census (www.statsghana.gov.gh/.../2010phc/Census2010_Summary_report_of_final_results

[17] Interim Report on the Ghana Burden of Disease Study, 2016 for 2013 data

[18] Draft 40-year National Development Framework (2018-2057), National Development Planning Commission (NDPC), Accra.

[19] Ministry of Health (2016) Holistic Assessment of the 2016 Programme of Work, 2014-2016.

[20] Ministry of Health: National Health Policy: Creating Wealth through Health, 2007

[21] Ministry of Health: National Health Policy 2020-2030: Ensuring the Right to Health through Universal Health Coverage (Working Document, undated)

[22] Ministry of Health: Health Sector Medium Term Development Plan (2018)

[23] This section greatly benefited from the field review of the OPM Consultants, Rachel Jenkin et al. (2018). Mental Health Situational Report, Ghana (unpublished).

[24] Read, U.M. and Doku, V. C.K, Mental Health Research in Ghana: A Literature Review, *Ghana Med J. 2012 Jun; 46(2 Suppl): 29–38.* PMCID: PMC3645145]

[25] Kessler, R., & Ustun, T. (eds.) (2008) *The World Health Organisation World Mental Health Surveys: Global Perspectives on the Epidemiology of Mental Disorders* (New York: Cambridge University Press).

[26] Bebbington, P., Jonas, S., Kuipers, E., *et al* (2011), Childhood Sexual Abuse and Psychosis: Data from a Cross-Sectional National Psychiatric Survey in England, *British Journal of Psychiatry*, 199(1): 29-37;

[27] Vostanis, P., Brugha, T., Goodman, R., *et al* (2006), Relationship Between Parental Psychopathology, Parenting Strategies and Child Mental Health: Findings from the GB National Study, *Soc Psychiatry Psychiatr Epidemiol*, 41: 509-514;

[28] Addo R, Nonvignon J, Aikins M. Household costs of mental health care in Ghana. J Ment Health Policy Econ. 2013;16(4):151-9.

[29] Maureen E Canavan, Heather L Sipsma, Achyuta Adhvaryu, Angela Ofori-Atta, Helen Jack, Christopher Udry, Isaac Osei-Akoto, and Elizabeth H Bradley. Psychological distress in Ghana: associations with employment and lost productivity. *Int J Ment Health Syst*. 2013; 7: 9. Published online 2013 Mar 7.

[30] Patel V, Chisholm D, Parikh R, Charlson FJ, Degenhardt L, Dua T, et al. Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities. *The Lancet*. 2016;387(10028):1672-85.

[31] Mark Roberts, Caroline Mogan, and Joseph B Asare (2014): An overview of Ghana's mental health system: results from an assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS). *Int J Ment Health Syst*. 2014; 8: 16. Published online 2014 May 4. doi: 10.1186/1752-4458-8-16
PMCID: PMC4016652

[32] Ssengooba M. 'Like a death sentence': abuses against persons with mental disabilities in Ghana. Human Rights Watch. 2012.

[33]Unshackling: Shantha Barriga. Ghana Breaks The Chains On Mental Health: Government Vows to Unshackle People With Psychosocial Disabilities. Human Rights Watch https://wwwhrworg/news/2017/10/16/ghana-breaks-chains-mental-health. 2017.

[34] WHOAIMS 2011

[35] Read, U.M. and Doku, V. C.K, Mental Health Research in Ghana: A Literature Review, *Ghana Med J. 2012 Jun; 46(2 Suppl): 29–38.* PMCID: PMC3645145]

[36] "Health Technology", World Health Organisation

[37] http://www.un.org/en/universal-declaration-human-rights/ (last accessed 7 May 2018)

[38] Shisha is an oriental tobacco pipe with a long, flexible tube which draws the smoke through water contained in a bowl.

[39] Synthetic opioid as pain killer but abused by the use

[40] Ministry of Health, National Alcohol Policy, 2017

[41] http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/ (last accessed 12 May 2018)

[42] Bertolote, J. & Fleischmann, A. (2002), Suicide and Psychiatric Diagnosis: a Worldwide Perspective, *World Psychiatry*, 1(3): 181-185.

[43] http://depts.washington.edu/mhreport/facts_suicide.php