

WHO-AIMS

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN GHANA**



**World Health
Organization**



**MINISTRY OF HEALTH
REPUBLIC OF GHANA**

WHO-AIMS REPORT ON MENTAL HEALTH SYSTEM

IN GHANA

A report of the assessment of the mental health system in Ghana using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).

2011



MINISTRY OF HEALTH
REPUBLIC OF GHANA



COLLEGE OF HEALTH
KINTAMPO



World Health
Organization

Southern Health
NHS Foundation Trust



*WHO, Accra Office
WHO, African Region
WHO Department of Mental Health and Substance Abuse (MSD)*

Table of Contents

ACKNOWLEDGEMENT.....	4
EXECUTIVE SUMMARY.....	5
WHO-AIMS COUNTRY REPORT FOR GHANA	
Introduction.....	7
1: Policy and Legislative Framework.....	9
Policy, plans, and legislation	
Financing of mental health services	
Human rights policies	
2: Mental Health Services.....	12
Organization of mental health services	
Mental health outpatient facilities	
Day treatment facilities	
Community-based psychiatric inpatient units	
Community residential facilities	
Mental hospitals	
Forensic and other residential facilities	
Human rights and equity	
Summary Charts	
3: Mental Health in Primary Health Care.....	20
Training in mental health care for primary care staff	
Mental health in primary health care	
Prescription in primary health care	
Domain 4: Human Resources.....	22
Number of human resources in mental health care	
Training professionals in mental health	
Consumer and family associations	
Domain 5: Public Education and links with other Sectors.....	26
Public education and awareness campaigns on mental health	
Legislative and financial provisions for persons with mental disorders	
Links with other sectors	
Domain 6: Monitoring and Research.....	27
Strengths and Weaknesses of the Mental Health System in Ghana.....	28
Next Steps in Strengthening the Mental Health System	32
References	36

Acknowledgement

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was administered in Ghana in 2012 to produce information on the mental health system for the year 2011.

The survey which was initiated by The Ministry of Health was coordinated and conducted by members of a Ghana / UK mental health and education partnership called The Kintampo Project that is helping to train new mental health workers for the whole of Ghana. A critical player and driver of this survey was the College of Health and Wellbeing, Kintampo which is the Ghanaian arm of the Kintampo Project partnership.

Key personnel were Professor. J.B. Asare (WHO-AIMS in-country Focal Point and former Chief Psychiatrist of Ghana), Dr Mark Roberts (UK Lead, The Kintampo Project), Caroline Mogan (Project Manager and Lead Researcher, The Kintampo Project) and Abena Anokyewaa Sarfo (Research Assistant, University of Ghana).

The WHO-AIMS survey would not have been possible without the generous financial support of the UK Department for International Development Health Partnership Scheme and direct funding from The Ministry. Grateful thanks are due for the continuous collaboration of the Ghana Health Service, mental health practitioners throughout Ghana, Ministry of Education, Ghana Police Service, Ghana Prison Service. Also thanked are all Regional Directors, The Chief Director and The Honourable R Mettle-Nunoo, Deputy Minister for Health.

The 'Kintampo Project' is thanked for their commitment and dedication to Ghana through the WHO-AIMS survey and their ceaseless drive to improve mental health services in the country.

Specific thanks are extended to the College of Health and Wellbeing, Kintampo without which this survey would not have been possible. The College provided administrative support throughout, conducted training for data collectors, arranged meetings, conferences, travel and much more.

Thanks are extended to senior stakeholders who have reviewed the report; Dr Akwasi Osei, Dr ET Adjase, Dr Armah Arloo, Dr Koku Awoonor-Williams, Ms Amina Bukari, Dr Anna Dzadey, Dr Techie Jones, Mr Lance Montia, Mr Joseph Nuerty, Dr Angela Ofori Atta, Dr Sammy Ohene, Mr Peter Yaro.

Thanks are extended to the Community Mental Health Officers and Mental Health Preceptors who assisted in the data collection.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS), the primary data collection method for this assessment, was developed by the Mental Health Evidence and Research team of the Department of Mental Health and Substance Abuse, World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO. Please refer to WHO-AIMS (WHO, 2005) for full information on the WHO-AIMS at the following website:

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Ghana for the year 2011. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Ghana to develop information based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention and rehabilitation.

A mental health policy, plan and mental health legislation exist in Ghana. Emergency and disaster plans for mental health do not exist. In 2011, 1.4% of total governmental health expenditure was directed towards mental health, however actual government spending on mental health will have been higher than this because the only budget that can be isolated is that spent on the 3 national mental hospitals, the rest cannot be calculated.

No mental disorders are covered by social insurance schemes. At least 80% of the population has free access to essential psychotropic medicines when they are available. A national human rights review body exists and all 3 national mental hospitals were inspected in 2011. There is no governing national or regional mental health body to provide advice to the government on mental health policies and legislation but that responsibility is vested in the Chief Psychiatrist.

There are 123 mental health outpatient facilities available in the country, of which none are for children and adolescents only. In 2011, these facilities treated 237 users per 100,000 general population. Female users make up 51% of the population in all mental health facilities in the country. The proportion of female users is highest in outpatient facilities (54%) and lowest in day treatment facilities (22%).

The majority of beds in the country are provided by mental hospitals (5.42 beds per 100,000 population). No beds in mental hospitals or community based inpatient facilities are reserved for children and adolescents only. There has been a decrease in the number of mental hospital beds in the past 5 years, although this has not been an intentional decrease, rather it has been due to breakages of beds with no funds for replacement. The density of psychiatric beds in or around the largest city is 7.23 times greater than the density of beds in the entire country.

The distribution of diagnoses varies across facilities. In outpatient facilities, “other” diagnoses (e.g. epilepsy) are most common whereas in community based inpatient facilities and mental hospitals schizophrenia has the highest prevalence. Psychotropic drugs are most widely available in mental hospitals, followed by community based inpatient facilities and then outpatient facilities.

Three percent of the training for medical doctors is devoted to mental health, in comparison to 14% of the training for nurses. No mental health care workers received mental health refresher training in 2011. In terms of physician-based primary health care

clinics less than 20% have assessment and treatment protocols available for key mental health conditions available.

The total number of human resources working in mental health facilities per 100,000 population is 7.83. There are 0.07 psychiatrists and 0.08 psychologists per 100,000 population. In terms of staffing in mental health facilities, there are 0.01 psychiatrists per bed in mental hospitals, in comparison to 0.08 psychiatrists per bed in community based psychiatric inpatient units. The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 2.72 times greater in the largest city than the entire country.

Ghana does have consumer associations for people with mental disorders but it does not have associations for families. There is no coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, professional associations and International agencies have promoted public education and awareness campaigns in the past five last years.

Although some schools in Ghana do have health professionals working within them, none of these are specifically trained in mental health. Regarding mental health activities in the criminal justice system, less than 2% of prisoners have contact with a mental health professional. There is no mental health training for police, lawyers, judges.

In terms of financial support for users, there are no social welfare benefits for people with mental disorders and less than 20% of mental health facilities have access to outside employment programs.

Ghana does have an information system for mental health and a formally defined list of individual data items that ought to be collected by all mental health facilities exists; however, the extent and completeness of the data collection is variable among facilities. Finally, of health related research. 1% is conducted on mental health.

Introduction

Ghana is a tropical country situated on the west coast of Africa. It shares boundaries with Togo to the east, La Cote D'Ivoire to the west, Burkina Faso to the north and the Gulf of Guinea to the south. The country covers 238,533 square kilometres. The population in 2010 was 24,392,000 of which, 51% live in urban areas (Population and Housing Census, 2010)

Ghana is one of the leading exporters of cocoa in the world and is a significant exporter of commodities including gold and timber. A recent [discovery of oil](#) in the Gulf of Guinea could make Ghana an important oil producer and exporter in the next few years.

The population is very much skewed towards younger people with 37.3% being under 15 years old, 51.9% age 16-59, 6.7% age 60-64 and 4.1% age 65 years and over. The life expectancy is 57 years for males and 64 years for females (WHO, 2010). The literacy rate is 67.3% (WHO, 2009)

English is the official language of Ghana and is universally used in schools in addition to nine other local languages. The most widely spoken local languages are Ga, Dagomba, Akan and Ewe (Ghana Embassy, 2012).

71.2 percent of the population are Christian, followed by Islam (17.6%), traditional religion (5.2%) and no religion (5.3%) (WHO, 2010a).

Health care delivery in Ghana is provided by both public and private sectors. The Ministry of Health exercises control over the whole system including policy formulation, monitoring and evaluation. Under the public health system, the service delivery is undertaken largely by Ghana Health Service, and teaching hospitals, both of which constitute the bulk of the Ministry of Health Institutions. In addition to that, other quasi government institutions and statutory bodies are also involved in health service delivery.

Ghana's mental health sector is funded primarily by government and is supplemented by internally generated funds and donations. Total health expenditure is 7.8% of GDP (2011). Per capita expenditure on health is US\$114.

This WHO-AIMS follows on from a previous survey of the Ghana mental health system for the year 2005 (Ofori-Atta, Read & Lund, 2010), but it is not compared with these 2011 survey findings because the 2005 survey was limited in scope and the findings generalised.

Data collection

The WHO-AIMS was used to collect, analyze, and report data on the mental health system and services for all districts of the ten regions of Ghana. Data was collected in 2012, based on the year 2011. The data collection phase was May-June 2012.

Process

1. The need to conduct the WHO-AIMS in Ghana was identified by the Ministry of Health and leaders of the Kintampo Project. Official sanction to conduct the survey was given by the Minister of Health.
2. The WHO-AIMS questions were divided into thirteen separate surveys, each targeting specific respondents. The item number, characteristic, and salient content of the questions were retained. Each questionnaire targeted one of the following respondents:
 - Chief Psychiatrist
 - Director / Chief Nursing Officer / Principal Nursing Officer of each Mental Hospital
 - Director / Chief Nursing Officer / Principal Nursing Officer of each Psychiatric Outpatient Facility
 - Head of each Community Based Psychiatric Inpatient Facility
 - Head of each Community Residential Facility
 - Chief Pharmacist
 - Head of Finance at Ghana Health Service / Mental Hospitals
 - Director of Family / Public Health at Ghana Health Service (GHS)
 - Head of Nursing and Midwifery Council / Medical and Dental Council / Directors of Nursing / Medical Schools
 - Director of Policy, Planning, Monitoring and Evaluation at GHS
 - Officer in Charge of Ghana School Health Education Programme
 - Director of Health, Ghana Police Service
 - Officer in Charge of Statistics, Ghana Prison Service
3. 10 pairs of Preceptor Community Psychiatric Nurses (CPNs) / Community Mental Health Officers (CMHOs) from College of Health (University, Kintampo (CoHK) were selected and trained to assist in the WHO-AIMS data collection in each of the ten regions.
4. Interviews were scheduled with each of the aforementioned respondents and conducted by Lead Researcher, Research Assistant or CPN / CMHO data collector pairs.
5. Data was entered into the WHO-AIMS 2.2 Excel spread sheet and discussed with the in-country Focal Point.
6. The Lead Researcher prepared and circulated draft reports to the in-country Focal Point, UK Project Co-Coordinator and Chief Psychiatrist for comments.

Once the initial draft WHO-AIMS report was ready, findings and further analyses were disseminated to Key Stakeholders in Ghana for consultation, refinement and contextualisation.

The findings of this survey have also been reported in a broad and detailed in-country report which is available on The Kintampo Project website www.thekintampo.org

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

Ghana's mental health policy was last revised in 1996 and includes the following components: (1) organization of services, developing community mental health services, (2) human resources; (3) involvement of users and families; (4) advocacy and promotion; (5) equity of access to mental health services across different groups; (6) financing; (7) quality improvement; and (8) a monitoring system, but it does not cover the integration of mental health into primary care nor the protection of human rights of the users. In addition, a list of essential medicines is present and was last revised in 2004. These medicines include: (1) antipsychotics, (2) anxiolytics, (3) antidepressants, (4) mood stabilizers and (5) antiepileptic drugs.

The last revision of the mental health plan was in 2007 (“2007-2011 Mental Health Strategy”). The plan contains the following components: (1) Organization of services: developing community mental health services and reforming mental hospitals to provide more comprehensive care, (2) Human resources, (3) Involvement of users and families, (4) Advocacy and promotion, (5) Equity of access to mental health services across different groups, (6) Financing, (7) Quality improvement, and (8) Monitoring system. In addition, budget, timeframe and specific goals are mentioned in the 2007 mental health plan. However, by 2011, lack of funds had prevented many of the goals being reached. There is currently no emergency / disaster preparedness plan for mental health.

In 2011 the ‘in-force’ mental health legislation was the Mental Health Decree NRCD 30” which was enacted in 1972. This legislation focused on; (1) Voluntary and involuntary treatment, (2) Law enforcement and other judicial system issues for people with mental illness. (3) Mechanisms to oversee involuntary admission and treatment practices (4) Mechanisms to implement the provisions of mental health legislation.

Financing of mental health services

Public funding for mental health

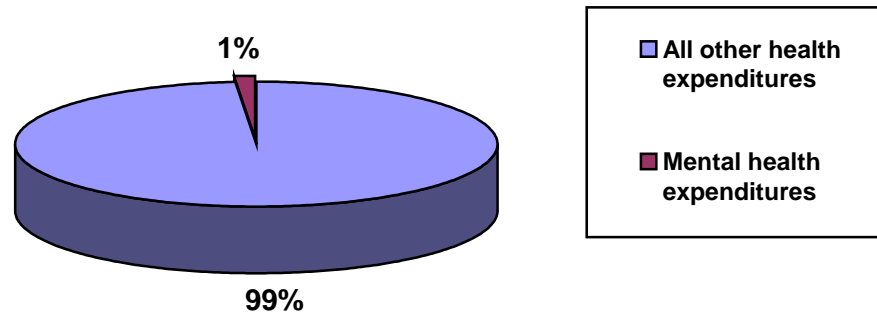
Figures from the Ministry of Health for 2011 show a ring-fenced mental health budget for the 3 mental hospitals of Ghana Cedi (GhC) 4,516,163 (without personal emoluments). However, the de facto spending on mental health in 2011 was GhC 5,656,974 because the funding that was initially approved was far lower than what was actually required and so it had to be supplemented.

Almost 100% of the ring fenced budget was spent on the 3 mental hospitals. Beyond this budget, mental health spending in Ghana is difficult to ascertain due to the integration of mental health into primary care where the delineations of services offered are more difficult to estimate. Money released for the Mental Hospitals covers overhead costs, including basic medical supplies and service maintenance.

Thus the spending on mental health was a minimum of 1.4% of the total health budget (graph 1.1). As noted, it is acknowledged that actual government spending on mental

health was higher than this however because the only budget that can be isolated is that spent on the mental hospital, the rest cannot be calculated.

GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



Other funding for mental health

In addition to public funding, mental health in Ghana is also funded by international development partners and to a small degree, by internally generated funds. A very small amount is also contributed by NGOs which purchase some medicines when the hospitals run out of government allocation. The additional moneys are pooled into a communal hospital fund and distributed across services within the hospital.

Mental health services do not usually generate revenue, since most patients are too poor to pay the fees and by government policy mental health care is supposed to be free. As a result, mental health services are subsidised by this system of pooling internally generated funds.

It is acknowledged that some mental health care is purchased directly by patients and their families via private services and the traditional / faith-based practitioner systems. Some patients are faced with having to buy their own medicines when government supplies run short. It is not possible to calculate the amounts spent these ways.

Human rights policies

A national human rights review body exists, which has the authority to oversee regular inspections of mental health facilities but it does not have the authority to review involuntary admissions / discharge procedures nor can it impose sanctions. Although the 1972 Mental Health Decree does have complaints investigation procedures, these were never put in place.

All three Mental Hospitals in Ghana had at least one external review / inspection of human rights protection of their users. Community based psychiatric inpatient facilities and community residential facilities were not inspected.

One of the mental hospitals had had at least one day training on human rights protection of patients in the past two years.

Access to psychotropic medicines & social insurance schemes

At least 80 percent of the population has free access to essential psychotropic medicines when they are available. However, due to a shortage of some psychotropic medicines, it is often the case that patients have to purchase these privately without means of gaining a refund. For those who pay out of pocket, the cost of a one day supply of the cheapest antipsychotic medication is 30% of the daily minimum wage. The cost of one a day supply of the cheapest antidepressant medication is 27% of the daily minimum wage.

No mental disorders are covered by social insurance schemes.

Psychiatric patients are in a difficult position because the social insurance schemes do not cover psychiatric care as it is expected to be provided free of charge by government, so consequently because of this and likely poverty too, psychiatric patients generally do not join the social insurance scheme. However, physical health care is to be provided via the social insurance schemes, so psychiatric patients who develop physical healthcare needs struggle to get these met.

Domain 2: Mental Health Services

Organization of mental health services

Ghana does not have a governing national or regional Mental Health Body. Service planning, monitoring and quality assessment of mental health services are thus not undertaken by any organised body but vested in the chief psychiatrist. Mental health services are not organized into catchment / service areas.

Although there was no national organizational body for mental health, the responsibility for national organization of mental health services was vested in the Chief Psychiatrist as the national head who also served to directly advise the Minister for Health on mental health. There was a focal person for mental health located in the Institutional Care Division of the Ghana Health Service, to coordinate mental health care in the Ghana Health Service institutions. The Chief Psychiatrist also coordinated planning and organization of mental health activities at the national level. At the regional and district levels the Regional and District Coordinators of Community Psychiatric Nursing served as the coordinators.

Mental health outpatient services

There are 123 mental health outpatient facilities available in the country, of which none are for children and adolescents only. In 2011, these facilities treated 57,404 users (237 users per 100,000 general population). 54% of the users were female and 14% were children and adolescents.

Regarding diagnoses, 39% of those treated were in the “other” diagnoses category (e.g. epilepsy, organic mental disorders, mental retardation). The rest included schizophrenia, schizotypal and delusional disorders (25%), mood disorders (10%), neurotic, stress related disorders (8%), mental and behavioural disorders due to psychoactive substance misuse (7%) and disorders of adult personality and behaviour (1%). The average number of contacts per user was 4.99.

88% of outpatient facilities provide clinic-based follow-up and 59% have mental health mobile teams. In terms of available interventions, approximately 20% of the users received psychosocial interventions. 40% the outpatient facilities had, at least, one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available on site or at a near-by pharmacy all year round.

Day treatment facilities

Ghana has one day-treatment facility, which is located in the Western Region. This is a private facility run by the Catholic Church providing users with a structured daily programme which includes pastoral care, psycho-education, psychomotor skills, occupational therapy and leisure activities such as games and crafts. It is staffed by 1 Therapist, 1 Psychiatric Nurse and 1 Hospital Assistant. In 2011 the service treated 18 users (0.07 per 100,000 general population), 3 of which were successfully discharged. Of all users treated in the day treatment service, 22% were females. 0% of users were 17

years or younger. On average, users spent two hundred and thirty nine days in the day treatment unit.

Community-based psychiatric inpatient facilities

There are 7 community-based psychiatric inpatient units available in the country for a total of 120 beds (0.50 beds per 100,000 population). 2 of which are private facilities with the remaining 5 being connected to regional hospitals. 47% of admissions to community-based psychiatric inpatient units are female and in spite of there being no beds available for children and adolescents only, 3% of the users treated last year in community-based psychiatric inpatient units were 17 years or younger.

The diagnoses of admissions to community-based psychiatric inpatient were primarily from the following three diagnostic categories: schizophrenia, schizotypal and delusional disorders (21%), Mental and behavioural disorders due to psychoactive substance use (9%) and mood disorders (6%). A further 6% of users had “other” diagnoses such as epilepsy or organic mental disorders. 0% of users had diagnoses of neurotic disorders or disorders of adult personality.

On average, users spent 16 days per admission. Records of physical restraint (mechanical and/or non-mechanical) and seclusion could only be found at 4 of the 7 facilities. These indicated that approximately 10% of users were physically restrained or secluded in 2011.

Some users (21-50%) in community-based psychiatric inpatient units received one or more psychosocial interventions in 2011. 57% of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility all year long.

Community residential facilities

There are 4 community residential facilities available in the country (of which 1 was provided by Ghana Health Service. The remaining 3 were privately managed). These facilities provide a total of 0.46 beds per 100,000 population. There are no beds reserved solely for children and adolescents. However 2% of users treated in community residential facilities in 2011 were 17 years or younger.

The number of users treated in community residential services in 2011 was 122 (0.46 per 100,000 population) with 46% of users being female. The average number of days spent in community residential services in 2011 was 365.

Mental Hospitals

There are 3 mental hospitals in the country with a total of 1322 beds (5.5 beds per 100,000 population). Two of which are located in the capital city and the other located in the Central Region of Ghana which is also in the south of the country. All of the hospitals are organizationally integrated with mental health outpatient facilities.

One hospital has a children's ward containing 15 beds. However, children will be accommodated in the other two hospitals if the need arises. In 2011, 1% of users treated were 17 years or younger.

In the last five years, the number of beds in mental hospitals has decreased by 13%, however, this has not been an intentional decrease, rather it has been due to breakages with no funds for replacement.. The number of admissions to mental hospitals in the year of assessment was 7993. 32% of these were female. The diagnoses of admissions to mental hospitals were primarily from the following three diagnostic categories: schizophrenia, schizotypal and delusional disorders (32%), Mental and behavioural disorders due to psychoactive substance use (26%) and mood disorders (19%). A further 1% of users had a diagnosis of neurotic, stress related disorder and 6% were classed as having "other" diagnoses such as epilepsy or organic mental disorders. 0% of users treated had diagnosis of disorders of adult personality.

Accurate data regarding the length of stay of users in mental hospitals was difficult to estimate due to insufficient record keeping of the large patient population and high turnover of users. However, based on data from 2 out of the 3 hospitals, 77% of users spend less than one year in hospital, 11% of users spend between 1-4 years, 5% of users spend between 5-10 years, and 7% of users spend more than 10 years in mental hospitals. These figures are estimated based upon a sample (4397 cases) of patients treated at Ankafu and Pantang hospital.

Records for the cumulative number of days spent that users spent in hospitals was also unavailable due to the aforementioned reasons. Therefore, based on the data from one hospital (2753 cases at Pantang) the average number of days spent in mental hospitals can be estimated at 23.6.

It is estimated that around 19% of users in mental hospitals received one or more psychosocial interventions 2011. In addition, 100% of mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility all year long. However, it is often the case that newer medicines (such as Olanzapine) would become depleted meaning that users would have to continue on medications that they had not been initially prescribed.

In 2011, none of the mental hospitals kept records on the number of users who were restrained (mechanical and/or non-mechanical) or secluded. However, estimated figures showed that over 20% of users were restrained or secluded in 2011.

Forensic and other residential services

There are 79 dedicated inpatient beds for forensic patients across the three mental hospitals, representing approximately 6% of the total. In 2011 there were 148 forensic admissions to mental hospitals (less than 2% of the total).

Other residential services include 10 services for children under 17 with intellectual disabilities across the 10 regions and one private school for children with intellectual

disabilities in Accra. There are 2 private residential services for people with substance abuse and one psychiatric hospital in Accra that has a detoxification unit.

Accra Psychiatric Hospital has 18 beds dedicated to old age patients. However there are no other specialised mental health services for older people, or people with conditions such as dementia.

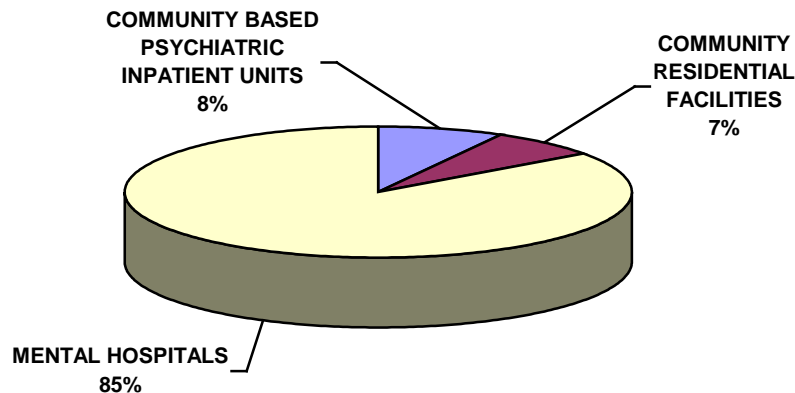
Human rights and equity

8% of all admissions in community based psychiatric inpatient units and 2% of all admissions to mental hospitals are legally sanctioned involuntary admissions. The remaining users were either voluntary or admitted against their will without the use of any legislation but with proxy consent by their relatives, and that was still considered to be 'voluntary'.

The density of psychiatric beds in or around the largest city (Accra) is 7.23 times the density of beds in the rest of the country. The solely 'coastal' and city based location of the hospitals prevents easy access for rural populations and those living away from the coast.

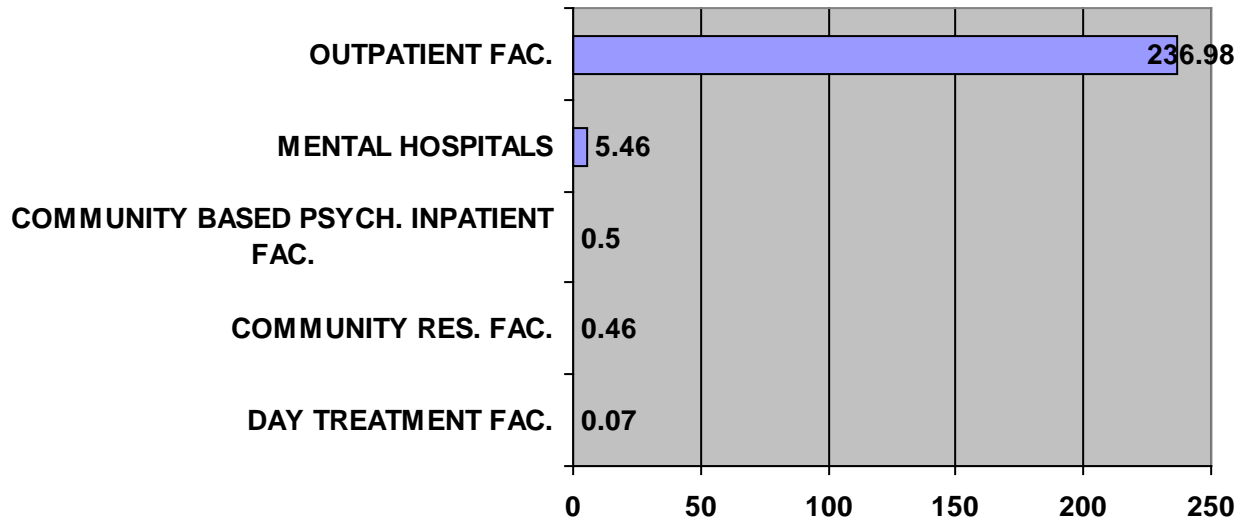
Summary Charts

GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



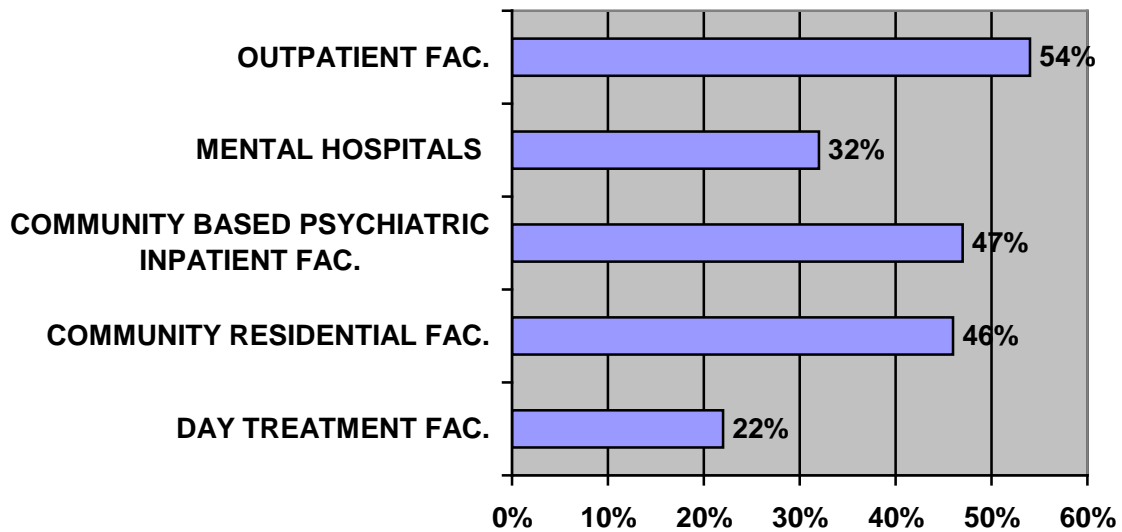
Inpatient beds are nearly all provided by mental hospitals, followed by community based psychiatric inpatient units and community residential services respectively (Graph 2.1).

GRAPH 2.2 - USERS TREATED IN MENTAL HEALTH FACILITIES (rate per 100,000 population)



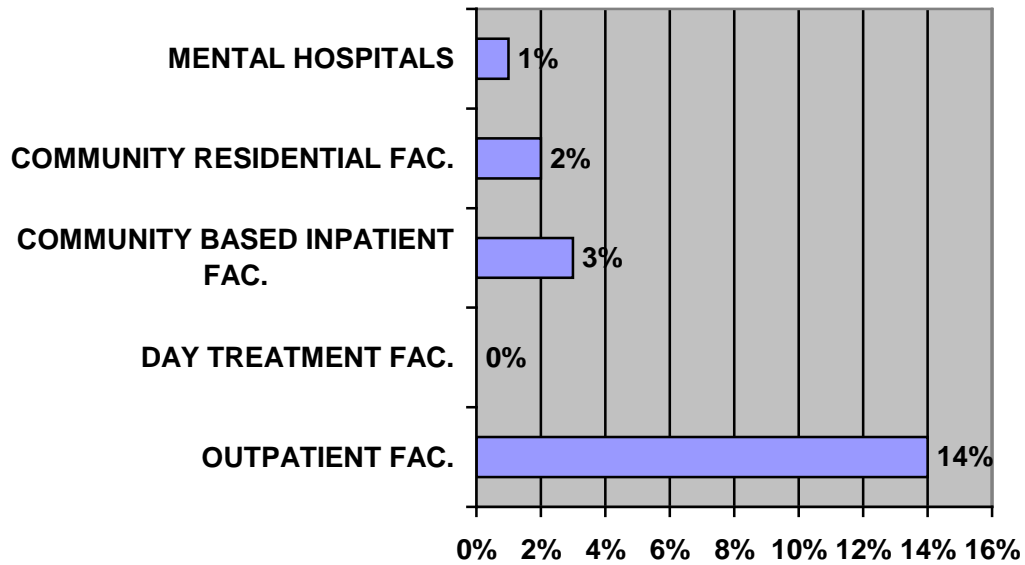
The vast majority of users are treated in outpatient services, while far fewer are treated in mental hospitals, general hospital /clinic based residential services, community residential services and day treatment services (Graph 2.2).

GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES



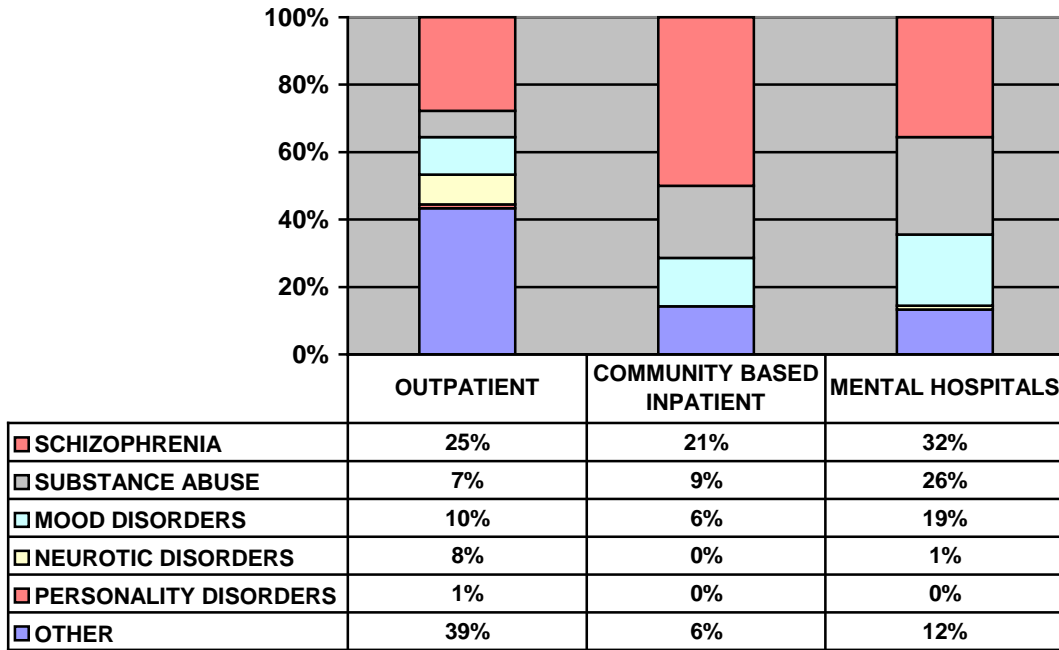
Female users make up approximately 51% of the population in all mental health services in the country. The proportion of female users is highest in outpatient services, general hospital /clinic based psychiatric inpatient units and community residential services. It is lowest in mental hospitals and day treatment services where there are fewer female than male wards (Graph 2.3).

GRAPH 2.4 - PERCENTAGE OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES AMONG ALL USERS



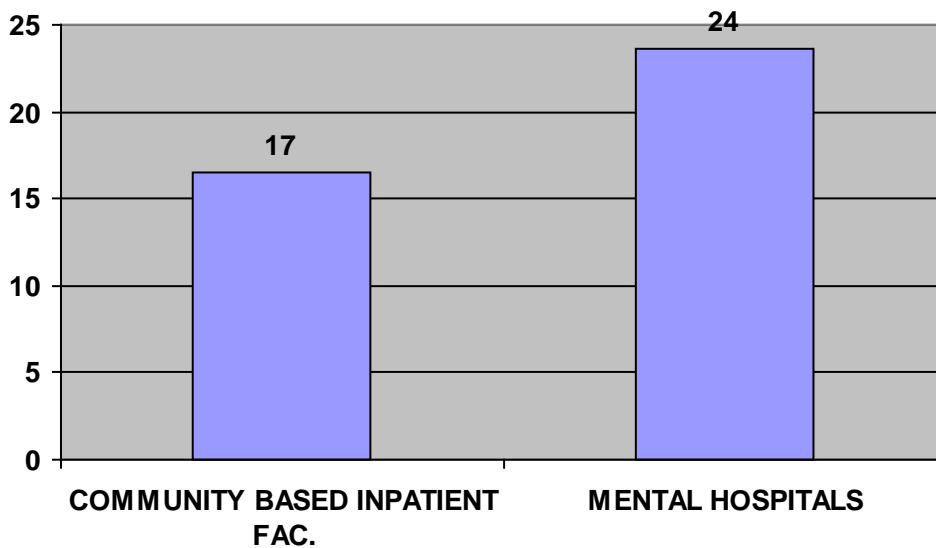
The proportion of children users treated for mental health problems is highest in mental health outpatient facilities and lowest in day treatment facilities.

GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS

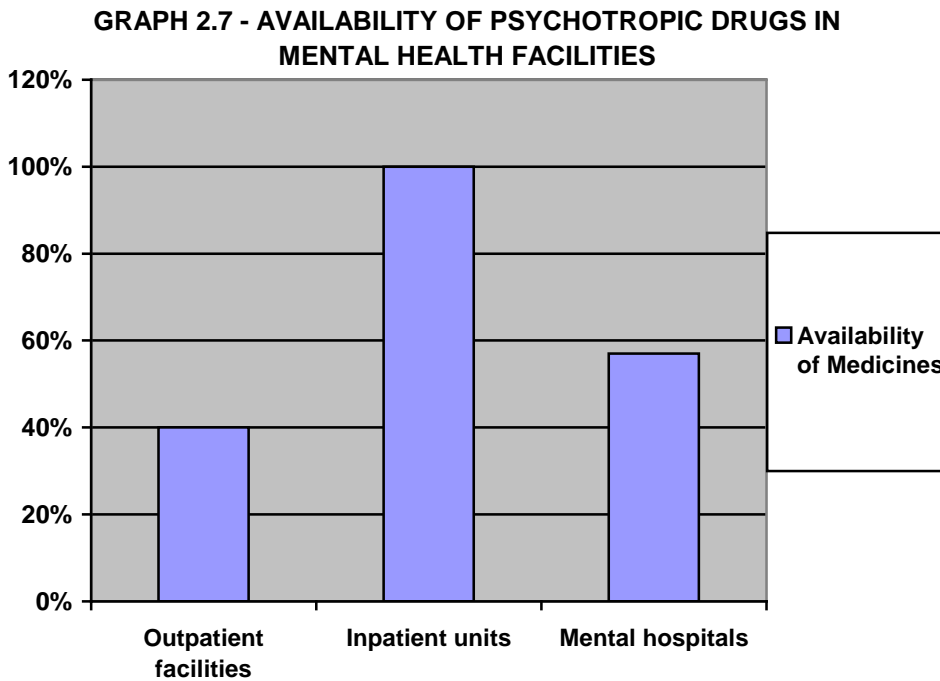


The distribution of diagnoses varies across facilities. In general hospital /clinic based psychiatric inpatient units and mental hospitals, schizophrenia and substance abuse are the most common diagnoses; whereas in outpatient services, “other” diagnoses such as epilepsy are most common (Graph 2.5).

**GRAPH 2.6 - LENGTH OF STAY IN INPATIENT FACILITIES
(days per year)**



The length of stay for users in mental hospitals is longer than in community based inpatient facilities. These figures have been rounded to the nearest whole number (Graph 2.6).



Psychotropic drugs are mostly available in mental hospitals, followed by general hospital / clinic based inpatient mental health facilities and then outpatient units (Graph 2.7).

Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

3% of undergraduate training for medical doctors is devoted to mental health. 10% of training for State Registered Nurses (SRNs) is devoted to mental health.

Non-doctor/non-nurse primary health care workers in the form of Community Health Workers are trained at the College of Health and Well Being in Kintampo. 14% of their training is dedicated to mental health.

Ghana Health Service reports that no primary health care staff received refresher training in mental health in 2011.

Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics were available in 2011.

In terms of physician-based and non-physician based primary health care clinics it is estimated that around 1-20% have assessment and treatment protocols available for key mental health conditions. These are offered in the form of “Standard Treatment Guidelines” that are available in booklet form.

There are no formal avenues for professional interaction between primary health care staff and other care providers so it is unknown how many PHC doctors had interactions or made referrals to mental health professionals in 2011. However, it is estimated that between 21-50% of non-physician based PHC providers make referrals to higher levels of care at least once per month.

There are no formal avenues for interaction between PHC staff (both physician based and non-physician based) with complimentary / alternative / traditional practitioners.

Informal primary health care (Faith-based and traditional practitioners)

People in Ghana, especially those from rural areas, will often visit traditional and faith based practitioners before or after seeking medical advice from the health system. Therefore it was deemed important to include a sample of these facilities in this survey.

10 faith-based and 10 traditional practitioners from each of the 10 regions were identified and interviewed to provide a snapshot of this type of informal community care. All of these facilities treated both mentally ill patients and patients with other (non-mental) illnesses.

Faith-based facilities

Across the 10 faith-based facilities, 1253 patients were treated in 2011. Of all patients treated in these facilities 37.5% were female (Graph 3.1) which is contrary to expectation

that more women attend faith-based healers than men and 8% were children or adolescents. The average number of contacts per user was 1.18.

Although ICD 10 is not used by faith-based practitioners, each stated that most of the users they treated had been given diagnoses of some kind prior to consultation.

In terms of available interventions, alongside spiritual practices, 56% of faith based healers also administered medications (which they reported buying in pharmacies) and 22% offered herbal remedies. Out of all of the users treated, 57.5% were restrained at least once across 8 facilities. The remaining two stated they did not use restraint or seclusion.

Staff in one of the ten facilities had received some training in psychiatric care in 2011. This had been provided by the regional hospital and by the NGO “BasicNeeds”. In addition, 2 facilities made referrals to psychiatric services in 2011.

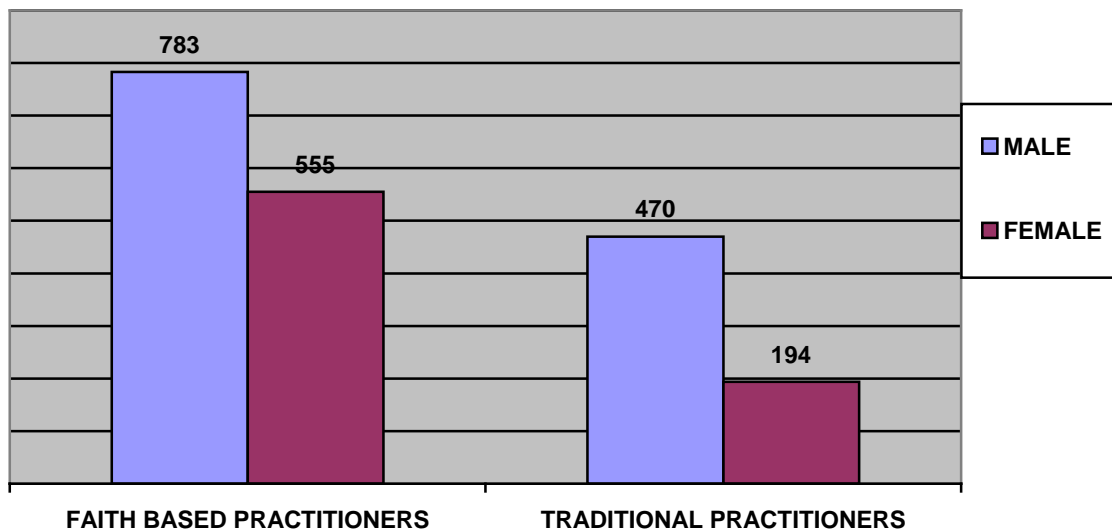
Traditional practitioners

Across the 10 traditional practitioner facilities surveyed, 749 users were treated in 2011. Of all users attending these facilities 39% were female (Graph 3.1) and 8% were children or adolescents. The average number of contacts per user was 1.19.

Like in the faith based facilities, ICD 10 diagnoses were not used but most users treated by traditional practitioners had previously been given diagnoses of some kind. In terms of available interventions, alongside using herbal remedies, 40% used “rituals” and 30% used spiritual practices. Out of all of the users treated, 41.1% were restrained at least once in 9 of the facilities.

Staff from one of the traditional healing facilities had received training in psychiatric care in 2011. This was provided by the regional hospital. 2 facilities made referrals to psychiatric services in 2011.

GRAPH 3.1 - NUMBER OF PEOPLE VISITING FAITH BASED & TRADITIONAL PRACTITIONERS FOR MENTAL HEALTH PROBLEMS

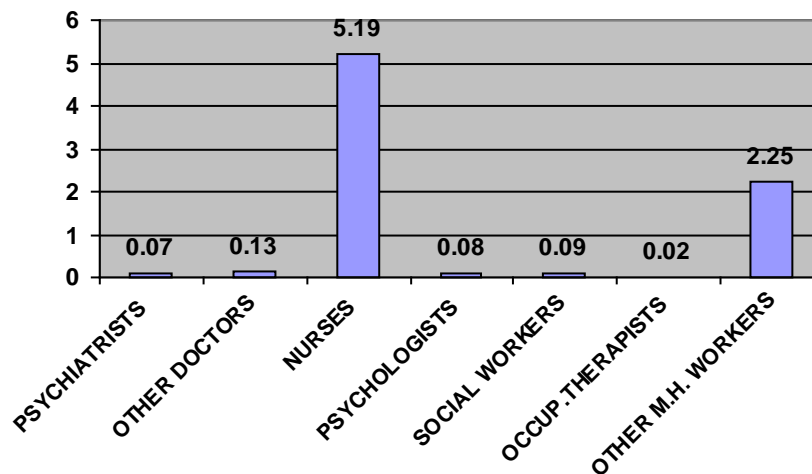


Domain 4: Human Resources

Number of human resources in mental health care

The total number of human resources working in mental health facilities per 100,000 population is 7.82. The breakdown according to profession is as follows: 18 psychiatrists (0.07 per 100,000 population), 31 other medical doctors, not specialized in psychiatry (0.13 per 100,000), 1,256 nurses (5.19 per 100,000), 19 Clinical psychologists (0.08 per 100,000), 21 social workers (0.09 per 100,000), 4 Occupational Therapists (0.02 per 100,000) and 546 other mental health workers (2.25 per 100,000) including auxiliary staff, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors (Graph 4.1)

GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)

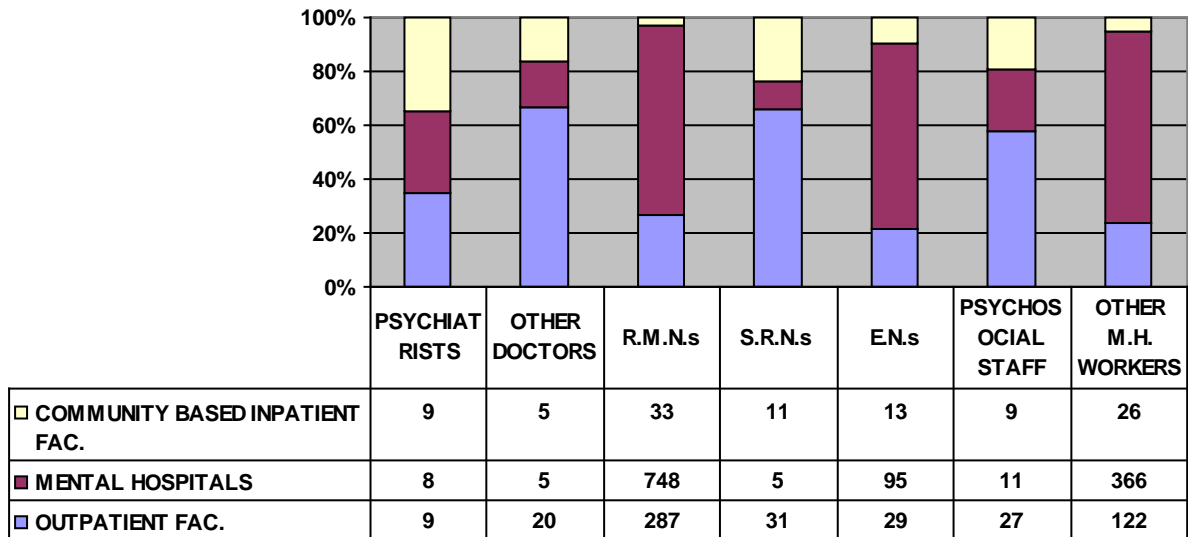


Regarding the workplace, most psychiatrists are located in more than one type of facility. 9 are based in outpatient services, 9 in community-based psychiatric inpatient units and 8 in mental hospitals. As for other medical doctors not specialized in mental health, 20 work in outpatient facilities, 5 work in community-based psychiatric inpatient units and 5 in mental hospitals. As for nurses, 347 (31 SRN, 287 RMN and 29 EN) work in outpatient services, 57 (11 SRN, 33 RMN and 13 EN) in community-based psychiatric inpatient units and 848 (5SRN, 748 RMN and 95 EN) in mental hospitals.

Twenty-seven psychosocial staff (Clinical psychologists, social workers and occupational therapy assistants) work in outpatient services, 9 in community-based psychiatric inpatient units and 11 in mental hospitals. Finally, for other health or mental health workers, 122 work in outpatient services (including 13 qualified Community Mental Health Officers, 1 Psychotherapist, 1 Non specified therapist and 107 Medical Assistants,

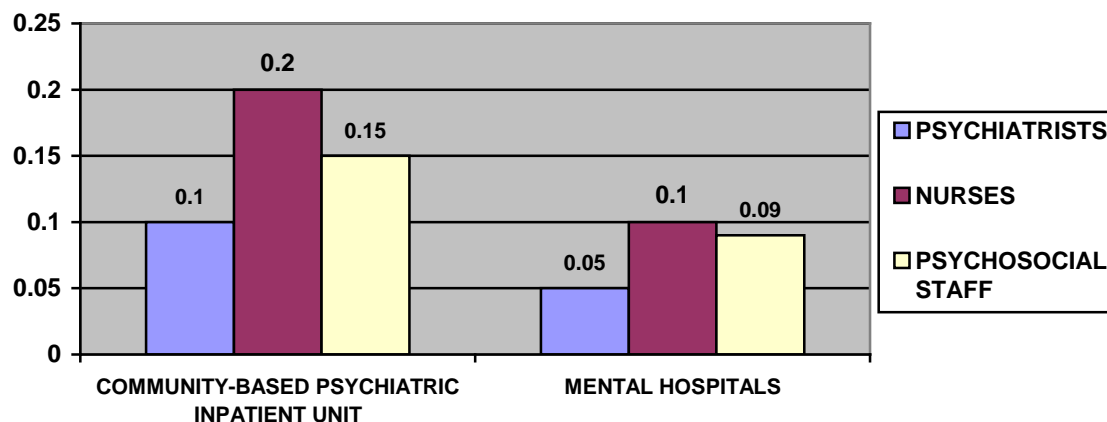
health extension workers or health care assistants), 26 work in community-based psychiatric inpatient units and 366 work in mental hospitals (Graph 4.2).

GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



In terms of staffing in mental health services, there are 0.08 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.01 psychiatrists per bed in mental hospitals. As for nurses, there are 0.48 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.64 per bed in mental hospitals. Finally, for other mental health care staff (ie psychologists, social workers, occupational therapists) there are 0.01 per bed in mental hospitals and 0.08 per bed in community-based psychiatric inpatient units (Graph 4.3).

GRAPH 4.3 - AVERAGE NUMBER OF STAFF PER BED



The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in government funded practice in or around the largest city is 2.72 times greater than the density of psychiatrists in the entire country (In Greater Accra there were 4 Psychiatrists in private practice in 2011. If these had been included in the calculation the ratio would increase to 4.28). The density of nurses is 4.44 times greater in the largest city than the entire country.

Training professionals in mental health

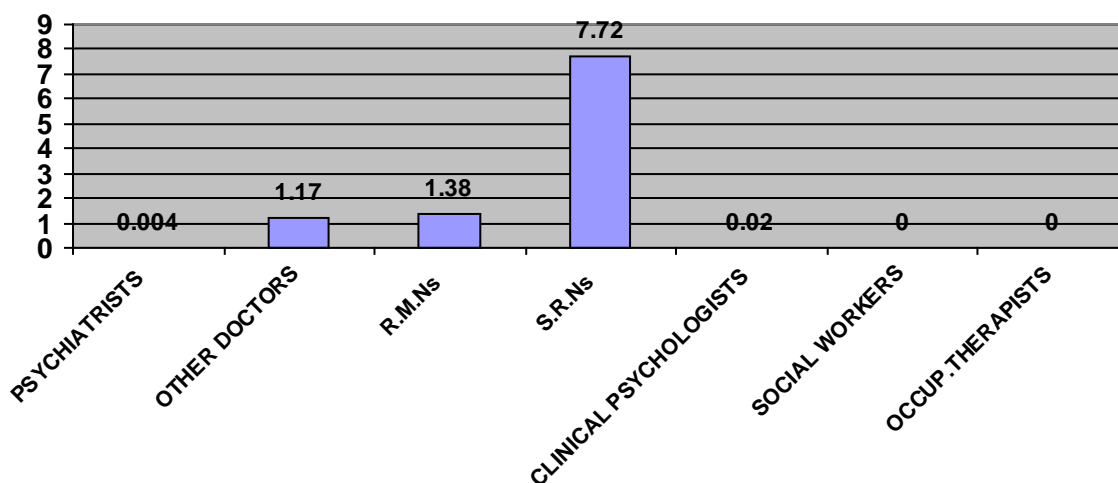
The number of health professionals graduated in 2011 in academic and educational institutions is 2494 (10.30 per 100,000). These included 1 Psychiatrist (0.004 per 100,000), 283 other medical Doctors not specialized in psychiatry (1.17 per 100,000), 1,871 State Registered Nurses (SRNs) (7.72 per 100,000), 334 Registered Mental Health Nurses (RMNs) (1.38 per 100,000), 5 Clinical Psychologists¹ (0.02 per 100,000), no Social Worker with at least 1 year training in mental health care and no occupational therapist.

In 2011 two new training programmes had been developed – Degree in Community Medicine and Clinical Psychiatry producing Clinical Psychiatric Officers (CPO) and Diploma Community Mental Health producing Community Mental Health Officers (CMHO).

The 2 year CPO course produces mental health practitioners who can practice independently where there are no psychiatrists, or complement psychiatrists where there are. The 1 year CMHO course produces frontline community level mental health workers to assist Community Psychiatric Nurses.

In 2011, 72 CMHOs graduated from the programme and started working around the country. The first batch of CPOs were set to graduate in 2012.

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



Consumer associations, family associations and NGO's

There are 10 consumer associations/NGOs in Ghana in These include Mental Health Society of Ghana (MEHSOG), The Ghana Mental Health Association, Mindfreedom, Alcoholics Anonymous, The Epilepsy Association, BasicNeeds, World Vision, The Epilepsy Society, Ghana Organisation against Foetal Alcohol Syndrome and Psycho-mental Health International.

A few (9%) of mental health facilities in the country had interactions with these associations in 2011.

BasicNeeds, MEHSOG and Mindfreedom have been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years in Ghana. Basic Needs and World Vision were also involved in individual assistance activities such as counselling, housing, or support groups in 2011.

Domain 5: Public education and links with other sectors

Public education and awareness campaigns on mental health

There is no overall coordinating body that oversees public education and awareness campaigns on mental health. However, this area of activity is overseen by a number of different organizations including the Ghana Mental Health Association.

Government agencies, NGOs, professional associations, and international agencies have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the general population and women. In addition, there have been public education and awareness campaigns targeting professional groups including health care providers and those working in the complimentary/alternative/traditional sector.

Legislative and financial provisions for persons with mental disorders

There is no legislative or financial support for the following: legal obligations for employers to hire a certain percent of employees that are disabled; protection from discrimination (dismissal, lower wages) solely on account of mental disorder; priority in state housing and in subsidized housing schemes for people with severe mental disorders; protection from discrimination in allocation of housing for people with severe mental disorders.

Links with other sectors

In terms of support for child and adolescent health, none of the primary and secondary (high) schools have either a part-time or full-time mental health professional but a few (1-20%) primary and secondary schools have school-based activities to promote mental health and prevent mental disorders. This is usually offered through teaching sessions by Community Mental Health Nurses.

Regarding mental health activities in the criminal justice system, a recent study conducted by the Officer in charge of statistics at Ghana Prison Service showed that the percentage of prisoners with psychosis is 0.7%. The corresponding percentage for mental retardation is also less than 2%. In addition, a few prisons (1–20%) have at least one prisoner per month in treatment contact with a mental health professional. However, it is usual practice that if a prisoner was to become mentally unstable whilst imprisoned, they would be sent to one of the psychiatric hospitals until they were fit to return.

With regards to training in the criminal justice system, 0% of police officers and 0% of judges and lawyers have participated in any educational activities on mental health in the past 5 years.

In terms of financial support for users, no mental health services have access to programs outside the mental health facility that provide outside employment for people with severe mental disorders. One community residential facility onsite training and workshops in order for its users to learn certain trades whilst residing at the unit. Items produced are sold to visitors.

Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health services exists. The extent of data collection is variable among mental health services (Table 6.1).

Table 6.1 - Percentage of mental health services collecting and compiling data by type of information

	Mental Hospitals	Community Inpatient Units	Outpatient Services
N° of beds	100%	100%	N/A
N° inpatient admissions/users treated in outpatient fac.	100%	100%	0%
N° of days spent/user contacts in outpatient fac.	67%	0%	100%
N° of involuntary admissions	100%	71%	0%
N° of patients Restrained (mechanical and/or non-mechanical)	0%	57%	0%
Diagnoses	100%	86%	96%

The government health department received some data from mental health services in 2011, although no official report covering the data was published.

In terms of research, 1% of all health publications from the country as identified by a PubMed search between 2006-2011 were on mental health. This research focused mainly on policy, programmes and financing/economics (38%). Other papers included services research (29%), epidemiological studies in clinical samples 19%, epidemiological studies in community samples (9%) and psychosocial interventions (5%).

Strengths and Weaknesses of the Mental Health System in Ghana

Strengths

The main strength is the presence of a long established mental health service with staff working across the country in outpatient departments and hospitals. The service is led by an able chief psychiatrist supported by other senior leaders. There are 3 large fully active mental health hospitals and a new mental health act has been passed which will refocus mental health services into the community and bring in robust structures for protection of human rights. Specifically, the provisions of the new Act include:

- Improving access to in-patient and out-patient mental health care in the communities in which people live.
- Human rights protection through regulation of mental health practitioners in both the public and private sectors and traditional healers too, everywhere in communities and hospitals.
- Combating of discrimination and stigmatization against people with mental illness and promoting their human rights.
- Promoting voluntary treatment
- Clearly defining and limiting the circumstances under which treatment may be given to people with mental disorders without their consent.

Strengths in domain 1: Policy and Legislative Framework

1. There are documented Mental Health Programmes with activities which are championed by the Chief Psychiatrist.
2. Mental Health service planning takes place and 5 year mental health plans are produced.
3. A budget line for mental health exists at the Ministry of Health even though it is not sufficient.
4. Government provides free treatment and accommodation for the mentally ill.
5. Psychotropic medication is available.
6. The country has a new modern Mental Health Act (as of the time of writing the report)
7. Hospitals have been inspected for Human Rights monitoring and some staff have had training.
8. Standard treatment guidelines are available
9. A national formulary which includes psychoactive medication is available.
10. Government recognises the mental health needs of the population and is supporting mental health service improvement.

Strengths in domain 2: Mental Health Services

1. Mental health is to some extent decentralized
2. There are some facilities for helping people with mental health problems in outpatients, inpatients and in the community. There are also traditional treatments for the mentally ill which are safe for some disorders.
3. Structures for providing mental health treatment and aftercare in the community are available.
4. A five-tier decentralised health system exists which mental health can integrate with.

Strengths in domain 3: Mental Health in Primary Health Care

1. Primary care practitioners are providing mental health services.
2. Working relationships exist with faith based and traditional healers.

Strengths in domain 4: Human Resources

1. There are some psychiatrists, although very few.
2. A range of practitioners exist including psychologists
3. Institutions for training doctors and nurses are available even to postgraduate level
4. Training programmes are in place producing middle level specialists in mental health
5. Opportunities exist in Ghana for postgraduate specialisation in mental health.

Strengths in domain 5: Public education and links with other sectors

1. Links exist with overseas mental health specialists and services, particularly in the UK and US.
2. NGOs for mental health and service user organisations exist.

Strengths in domain 6: Monitoring and Research

1. Mental health service informatics is good enough to be able to produce data for assessing the system (for example this report).
2. Research on mental health is taking place.

Weaknesses

The main weakness is that government spending on mental health is very low. The bulk of the services are centred on the heavily populated capital city of Accra leaving much of the rest of country with only very sparse provision. Development of the mental health system has been neglected despite pressure and campaigning from able mental health leaders in the country and the mental health law passed in 1972 was never actually implemented. Service provision is dominated by nurses with few other professional groups present in any number. When compared to other LIC and LMIC countries Ghana is at the LIC level although it became officially LMIC in 2011.

The weaknesses include the following;

Weaknesses in domain 1: Policy and Legislative Framework

1. Insufficient funding has compromised effective service delivery particularly area coverage.
2. There is a lack of regional and district management structures for mental health with multiple negative consequences including very inadequate systems for planning, monitoring, service and quality improvement
3. The system is too strongly focused on inpatient care
4. There is very little use of legislation to regulate detention of patients thus widespread breaching of human rights
5. The supply of psychotropic medications is not consistent or uniform in coverage.
6. There is a lack of policy and regulation concerning the practice of psychiatry by faith based practitioners.
7. There is insufficient use of clinical guidelines even where they exist.

8. There is inadequate legal and financial support for people with mental disorders in the areas of employment and housing.
9. There is only low potential for Internally Generated Finds (IGF) as service users are usually poor.

Weaknesses in domain 2: Mental Health Services

1. Insufficient in-patient facilities in the Regions and Districts has put burden on families who have to travel long distances in search of treatment.
2. There is overcrowding in some of the inpatient facilities.
3. There is a very low level of community based rehabilitation facilities.
4. Management of substance abuse is deficient outside psychiatric institutions.
5. There is inequitable distribution of resources such that nearly all the resource is provided via 3 hospitals located in large urban centres in the south.
6. The few rehabilitation units which exist are 'blocked' by long stay patients.
7. There are high rates of restraining (mechanical and/or non-mechanical) and secluding disturbed patients.
8. Patients are being secluded and restrained when not formally detained.
9. Supply of community mental health facilities (eg office and clinic space) and resources (eg medication supplies and transport) to support community mental health practice is very insufficient.
10. There is a lack of services specifically for children.
11. There is only one day treatment centre in the country whereas there should be several hundred.
12. The number of community based psychiatric inpatient units is very inadequate.
13. The number of community residential facilities is very inadequate.
14. There are insufficient specialist services, particularly in the case of children, old age, learning disabilities, forensic, substance misuse.

Weaknesses in domain 3: Mental Health in Primary Health Care

1. Mental health services have to be provided by inadequately trained staff, such as generic health workers.
2. There is a lack of referral systems for healthcare workers to know how to refer cases into the mental health system.
3. Traditional practitioners are restraining patients without legal authority to do so, which is breaching human rights.

Weaknesses in domain 4: Human Resources

1. There is insufficient manpower particularly, psychiatrists, psychologists, occupational therapists, workers trained for community mental health practice and psychiatric social workers.
2. There are insufficient incentives for staff working for mental health.
3. Mental health staff and primary health care workers are hardly doing any refresher training at all.
4. There is hardly any training of mental health workers on human rights.
5. The balance of treatment for patients is too strongly focussed on medication rather than psychosocial interventions and prevention.
6. The amount of postgraduate training taking place in psychiatry for doctors is very low.
7. Very few doctors choose to specialize in mental health.

Weaknesses in domain 5: Public education and links with other sectors

1. There is insufficient public education which is likely to adversely affect acceptance of the mentally ill in the community and their rehabilitation.
2. There is no coordination of public education / awareness raising campaigns etc. for mental health.
3. Criminal justice personnel have had no mental health training.
4. There is inadequate information on the prevalence of mental health problems in prisons.

Weaknesses in domain 6: Monitoring and Research

1. The mental health information system is not adequate, it is not being used consistently enough and data is not being aggregated and reported.

Next Steps in Strengthening the Mental Health System

The priorities which are likely to assist the realisation of the detailed areas in domains 1-6 below are;

- 1 Although the new Mental Health Act 846 of 2012 has enabled the creation of a Mental Health Authority government should now urgently appoint and establish the Mental Health Board.
- 2 For The Mental Health Board to develop the Legislative Instrument for the Act, for Parliament.
- 3 For Parliament to agree a budget for implementation of the Mental Health Act.
- 4 For mental health structures described in the Act to be put in place as soon as possible at all levels across districts, regions and nationally.
- 5 To introduce the Act to the public and for there to be education of stakeholders.
- 6 To commission an expert team to work in collaboration with MoH and health providers to produce evidence based mental health improvement plans with short, medium and long term goals. The plans should take into account needs in relation to the implementation of the Mental Health Act and needs from the findings of the WHO-AIMS survey in relation to Ghana's status as a lower-middle income country.
- 7 To follow up the work of the expert team (in 5 above) with the implementation of a staged project plan which is well managed by experts in project management.

The following should be taken into account when producing the mental health improvement and action plan;

Next steps - domain 1: Policy and Legislative Framework

1. The budget for mental health in Ghana needs to be increased through dedicated funding which should be properly managed for the expansion of mental health services in the community
2. The provisions in the Mental Health Act 846 of 2012 which make room for the following, should be specifically implemented as soon as possible in order to enhance human rights;
 - a) Visiting committees to protect the rights of patients and ensure care and treatment is of the requisite standard across all facilities in the community and hospitals whether orthodox or unorthodox.
 - b) Mental Health Review Tribunals to investigate complaints review the detention of patients and control the use potentially harmful interventions.
3. The organizational structure of the Mental Health Authority should include a division for Quality Assurance and a division for Monitoring and Evaluation.
4. Training/awareness creation and monitoring plans should be produced for the changes that will occur from the implementation of the Mental Health Act..
5. In the spirit of decentralization, measures should be put in place to track funds released to the service to ensure work is integrated and monitored.
6. During the initial stages of the implementation of the Act, at least for the next 5 years, selected psychotropic medication should be included in the National Health Insurance Scheme. Subsidy should be given to the new generation psychotropic drugs by the Authority.

7. The Mental Health Authority should establish a system to maintain oversight of and to coordinate all the different groups working alongside government contracted and private mental health service providers in the country. These 'groups' include consumer associations, family associations, NGO's and groups and individuals from overseas. The task should include the coordination of the efforts of these 'groups' and ensuring their work is in line with the mental health strategy of the country. There should be some visibility of the different groups and what they do perhaps via a website or an easily available and regularly updated 'register'.

Next steps - domain 2: Mental Health Services

1. Organized catchment areas/services should be introduced throughout the country.
2. Children and adolescents are the future adult citizens of the country. They represent almost 40% of the population and accordingly require a concentrated focus for mental disorder prevention programmes as well as treatment for those who are already afflicted by mental health problems. These needs are currently outstanding and they should be urgently addressed. There should be at least one comprehensive adolescent mental health service in each region providing, in-patient, outpatient and rehabilitation facilities where counselling, social skills training and prevention programmes can be administered. Child and adolescent mental health should be considered as the first area to develop as a specialism once all practitioners have developed the requisite basic skills in it.
3. There should be at least one day treatment facility in each region. Many more than this will eventually be needed but at least one per region would be in the right direction. Day treatment facilities help to provide care-givers with some reprieve and also prevent inpatient care to some extent. They offer accessible opportunities for rehabilitation and improvement on social and communication skills.
4. The discrepancy whereby mental health services are concentrated in Accra should be addressed in the implementation of the Act through decentralization and refocusing on community care.
5. The paradigm shift from institutional to community care as envisaged by the Mental Health Act, calls for downsizing or total abolition of the Accra Psychiatric Hospital and the retraining of the staff for community based activities.
6. The policy of de-emphasizing institutional care and the provision of mental health services in the regions and districts should be continued. This policy calls for existing staff to retrain for community mental health and other areas.
7. The Mental Health Authority should pursue the provision of a forensic facility in a maximum security prison.
8. Forensic wards in the psychiatric hospitals are inadequate and are staffed by nurses who have no adequate training for the job, which presents unacceptable risks to patients, staff and visitors. This should be rectified by providing proper facilities and training for all staff managing such patients.
9. Specialized treatment facilities and staffing should be made available for the aged.

Next steps - domain 3: Mental Health in Primary Health Care

1. In order to successfully decentralize and integrate mental health services, it is imperative that programmes are put in place to train new non-mental health workers in the Primary Health Care system and existing primary care practitioners

- should be provided with specific training in mental health for public education, case detection, support and referral of cases.
2. The essential drug list should be updated and a policy developed to guide the availability of psychotropic drugs at various levels commensurate with levels of training of practitioners.
 3. Treatment protocols and algorithms should be developed for Primary Health Care providers. These should include recommended appropriate psychotropic medication for use at the Primary Health Care level. The medication in the protocols should be available at all times.
 4. Referral systems between primary care and mental health should be formalised with standard national procedures so that everyone knows the system and what to do. This should become possible with the establishment (via the Act) of Regional and District Mental Health Sub-Committees, although the Board will still need to lead this for it to become established.
 5. A series of meetings should be organized with traditional and faith based healers (non-orthodox mental health practitioners) to harmonize their integration and their practices in line with the Mental Health Act.
 6. Clear policy guidelines for the practice of non-orthodox mental health practitioners should be produced.
 7. Traditional and faith based healers should be trained on the new Mental Health Act particularly their obligations in relation to the human rights of patients.

Next steps - domain 4: Human Resources

1. The human resource base should be expanded at all levels particularly, Psychiatrists, Clinical Psychologists, Psychiatric Social Workers and Occupational Therapists.
2. Special incentives should be considered for mental health practitioners to improve the manpower situation. This should include incentives to attract personnel into the training facilities in the country and to recruit others from the Diaspora. This has been tried and tested to good effect in some other countries, for example in the UK where very attractive pension allowances were introduced to attract doctors to become psychiatrists and even to this day mental health staff receive a 'risk allowance' for working in the specialty despite the fact that working in mental health in the UK is vastly safer than it is in Ghana.
3. It is heart-warming that training of mental health personnel at different levels is ongoing locally in Ghana and the level of brain drain which was rampant years back has reduced.
4. The vision and now, practice, of training middle level personnel to help cover the Regions, Districts and Sub-Districts, is in the right direction and should be supported vigorously.
5. The College of Health at Kintampo should be adequately resourced for mental health training and priority should be given to training more Community Mental Health Officers and Clinical Psychiatric Officers.

Next steps - domain 5: Public education and links with other sectors

1. The Mental Health Authority should ensure there is implementation of legislation to protect the mentally ill with regards to employment, accommodation and access to treatment which should include access to physical health care treatment for those who cannot afford to be part of the National Health Insurance Scheme.

2. The Authority should consider the creation of centres that will employ the mentally ill, stimulating self-sufficient employment e.g Industrial Rehabilitation Centres.
3. Advocacy groups apart from the Mental Health Act statutory Visiting Committees should be encouraged to set up for the benefit of the mentally ill.
4. A Division or Unit should be created at the Mental Health Authority to coordinate continuous mental health promotion in the country.
5. Mental health promotion and targeted efforts to reduce stigma should be pursued vigorously

Next steps - domain 6: Monitoring and Research

1. Health information systems and record keeping should be improved to facilitate data collection and analysis. Information systems should be properly managed and training in recording and keeping of records in line with modern techniques should be enforced. During the WHO-AIMS survey, the data collectors had to go into registers to remove double counting as practised at many centres. The trained data collectors from the regions can be deployed to train data recorders in their regions and districts.
2. The Authority should organize update courses for clinicians to improve on diagnosis and recording of cases seen.
3. Monitoring and evaluation systems supported by trained staff should be put in place and enabled to be effective.

References

Ghana Embassy, 2012. *Language and Religion*. [online] Available at: <<http://www.ghanaembassy.org/index.php?page=language-and-religion>> [Accessed 7 September 2012]

Ofori-Atta, A., Reed, U. & Lund, C. (2010). A situation analysis of mental health services and legislation in Ghana: Challenges for transformation. *African Journal of Psychiatry* 13, pp 99-108

Population and Housing Census (Ghana), 2010. [online]. Available at: <<http://www.ghana.gov.gh/census/phc2010.pdf>> [Accessed 7 September 2012]

WHO (2007). *Ghana: A very progressive mental health law*. Department of Mental Health and Substance Abuse. WHO: Geneva.

WHO, 2009. *Ghana: Country Cooperation Strategy: At a Glance* [online] Available at: <http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_gha_09_en.pdf> [Accessed 7 September 2012].

WHO, 2010. Ghana: Health Statistics Profile 2010 [pdf] Available at: <<http://www.afro.who.int/en/ghana/country-health-profile.html>> [Accessed 7 September 2012].

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Ghana for the year 2011. The goal of collecting this information is to improve the mental health system to provide a baseline for monitoring change.

In 2011, Ghana had a mental health policy, plan and legislation in place and 1.4% of the total governmental health expenditure was directed towards mental health.

There were 123 mental health outpatient facilities, 3 mental hospitals, 7 community based psychiatric inpatient units, 4 community residential facilities and 1 day treatment centre. The majority of users were treated in outpatient facilities and mental hospitals and most of the inpatient beds were provided by the latter.

There were 18 psychiatrists, 1256 nurses, 19 clinical and psychologists, 21 social workers working in mental health.

The main strength of the mental health system was the presence of a long established service with staff working across the country in outpatients departments and hospitals. There was also a new mental health act which will refocus services into the community and bring in structures for the protection of human rights.

The main weakness is that government spending on mental health is very low and that the bulk of services are centred around the capital city leaving much of the rest of the country with sparse provision. In addition, services are dominated by nurses with few other professional groups present.