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Stakeholders' perceptions of the main challenges facing Ghana's mental health care system: a qualitative analysis

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Mental health remains a low priority in Ghana. No comprehensive studies have assessed the current status of mental health policy, legislation and services in Ghana. This paper presents the qualitative results of a situation analysis conducted as part of the first phase of the Mental Health and Poverty Project. The aim of this paper was to explore what a range of stakeholders perceive as the main challenges facing Ghana's mental health system and the primary ways of addressing them. A total of 81 interviews and seven focus groups were held with key stakeholders drawn from five of the 10 regions in Ghana. The major challenges identified included: inadequate implementation of mental health policy; legislative limbo; inadequate human and financial resource; widespread stigma; dominance of psychiatric hospitals; and insufficient human rights protections for the mentally ill. A range of policy, legislative and service-related recommendations were made for addressing the situation. The results revealed that mental health services in Ghana need to scaled-up to respond to unmet needs in ways that are cost-effective within the budget of a low-income country. Enacting the current mental health bill and identifying strategies for overcoming the barriers to policy implementation will mark significant steps forward.

Keywords: mental health system; Ghana; challenges; qualitative study

Introduction

Despite significant economic growth in recent years, Ghana is classified as a low-income country, with 28.5% of the population living in poverty and 18.2% living in extreme poverty (World Bank, 2007). These figures, however, conceal significant regional variation between the urban coastal areas and the northern regions, with 87.9% of the population of the poorest region, Upper West, living in poverty, compared to 11.8% in the capital (Government of Ghana, 2007). This economic situation has implications for mental health, given the emerging evidence from low-income countries that mental illness is associated with poverty and the many aspects of social deprivation with which poverty is associated (Flisher et al., 2007; Lund et al., 2007). Indeed, although there are no comprehensive data on the incidence and prevalence of mental disorder in Ghana, it is estimated that at least 13% of the adult population are likely to suffer from a mental disorder, with 3% of these suffering

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from a severe mental disorder and 10% suffering from a mild to moderate mental disorder (WHO, 2007).

Despite widespread poverty and underdevelopment, and the related high burden of mental illness, mental health remains a low priority in Ghana, with much remaining untreated by mental health services. The limited data that exists suggests that mental health policy and legislation are outdated and financing for mental health is inadequate to meet the needs of the population (Awenva et al., in press). Despite some efforts towards the reform and expansion of mental health care, little progress has been made. Mental health services continue to labour under institutional patterns of care, while international trends are towards the downscaling of psychiatric institutions and the provision of community-based mental health services and the integration of mental health services into general health services (Geller, 2000; Thornicroft & Tansella, 1998). Decentralisation of mental health services has only occurred on a limited scale and community-mental health services are inadequate (Bossert & Beauvais, 2002). Mental health care remains focused on pharmacological, with little provision for psychosocial interventions such as psychosocial rehabilitation (Roberts, 2001). Whilst a new mental health bill has been drafted, there are concerns as to when it will be passed and to what extent the bill will be implemented in practice.

There is very little published research on mental health in Ghana. Between 2000 and 2005, three articles were published on mental health in Ghana as identified on PubMed. These were a survey of resource utilisation for mental disorders (Ferri, Chisholm, Van Ommeren, & Prince, 2004), a survey of help-seeking behaviour for mental illness in Kumasi (Appiah-Poku, Laugharne, Mensah, Osei, & Burns, 2004) and a descriptive commentary of the mental health situation in Ghana (Roberts, 2001). This represents about 1% of all articles on health in Ghana as identified on PubMed. To the authors' knowledge, no large-scale and comprehensive studies have been conducted on the mental health system (including policy, legislation and services) in Ghana.

This paper presents the qualitative results of a situation analysis of the current status of mental health policy, legislation and services in Ghana, which was conducted as part of the first phase of the Mental Health and Poverty Project (MHaPP). To date, MHaPP is the first comprehensive situation analysis of the mental health system in Ghana (see Ofori-Atta, Read and Lund [in press], who reported results from the quantitative component of the study). The MHaPP, which is being conducted in four African countries (Ghana, South Africa, Uganda and Zambia), aims to investigate the policy level interventions that are required to break the vicious cycle of poverty and mental ill-health, in order to generate lessons for a range of low- and middle-income countries (Flisher et al., 2007). The objective of this particular paper was to explore what key stakeholders, ranging from consumers, academics, health care workers and program managers and policy makers in and outside of the Ministry of Health, perceive to be the main challenges facing Ghana's mental health system. It also sought to highlight what these key stakeholders perceive to be the primary ways of addressing these issues. By giving voice to a wide scope of views across Ghanaian society, this study will offer opportunities to identify what fundamental obstacles are facing mental health policy, legislation and services in order to better address the mental health needs of the country.

Methods

Eighty-one interviews and seven focus group discussions were held with policy makers, health professionals, users of psychiatric services, teachers, police officers, academics and religious and traditional leaders drawn from five of the ten regions in Ghana. The interviews and focus group discussions were conducted with 122 respondents, who were purposively sampled from among the major stakeholders in mental health at the national, regional and district levels. Thirty-five interviews were held at the national level and 23 at the regional level. One focus-group discussion was held at the national level.

Semi-structured interview guides were tailored according to the specific individual being interviewed. Topics covered included general policy making process in Ghana, the process of mental health policy and legislation development, the role of stakeholders in mental health policy and legislation development, the content of the current mental health policy and legislation and the implementation of mental health policy and legislation at the national and regional levels.

Interviews were digitally recorded with participants' consent and transcribed verbatim. Interviews in Twi, a local language, were first transcribed and then translated into English by staff of the Bureau of Ghana Languages. All transcripts were entered into Nvivo 7, which was used for coding and analysis. A framework analysis approach was adopted (Ritchie & Spencer, 1994) in which certain themes were agreed upon by investigators from all four study countries, based on the objectives of the study. From these objectives, sub-themes were suggested by country partners and reviewed by all partners through a process of iteration, until a single framework was agreed upon that could be used by all four study countries. Where specific themes emerged from the interviews that were not included in the generic cross-country framework, these were added to the coding frame, to adapt the analysis to issues specific to Ghana. Transcripts were coded on the basis of these themes, with additional themes added to the coding framework as determined by the data. Interviews were coded independently for 10% of randomly sampled interviews to ensure inter-rater reliability. Inter-rater reliability was always above 90%.

Ethical approval was granted by the Ghana Health Service Ethics Committee at the national level and the Institutional Ethics Board at Kintampo Health Research Centre.Information sheets containing all the essential information about the study and the implications of participation were submitted to all participants. Participants were then requested to sign a consent form to indicate their willingness to participate in the study. Participants who were unable to read had a witness read the information sheet and consent form to them in Twi before agreeing to participate in the study. These participants were requested to provide a thumb print in lieu of a signature in the presence of a witness. The names and other identifying features of the respondents were removed from the transcripts in order to ensure confidentiality.

Results

Several major challenges facing Ghana's mental health care system will be described and illustrated with excerpts from interview transcripts. Stakeholders' perceptions regarding some of the best ways of addressing these issues will be interwoven into the results.

Inadequate implementation of mental health policy

Current mental health policy in Ghana was formulated in 1994 and revised in 2000. The vision statement of the current policy includes human rights, social inclusion and some commitment to evidence-based practice. Many of the policy's aims are consistent with World Health Organisation's (WHO) mental health policy objectives for co-ordination and management of mental health services, promoting de-institutionalisation and community-based mental health services, the training of mental health workers and the need for promotion, prevention and rehabilitation in mental health.

Despite the development and revision of mental health policy in Ghana, it became clear that the policy has been inadequately implemented. A repeated theme across the different groups of stakeholders nationally and regionally was the scantiness of policy implementation. As one psychiatric nurse at the national level explained:

> The problem in Ghana, and it cuts across, the policies will be formulated but the implementation becomes always a problem in every sector. So I'm not surprised that in psychiatry some of these policies they are very nice, nicely framed, but to implement them, the problems, you understand?

A plethora of reasons emerged as to why there has been poor implementation of the mental health policy. Firstly, a lack of awareness and knowledge of the policy emerged as a fundamental obstacle to its implementation. One is constantly struck by the way in which mental health professionals, primary health care workers, other professional groups and the general public appeared to lack an awareness of the policy. In response to questions such as: 'What are your views of the mental health policy' and 'Are you aware of the mental health policy', the interviews were saturated with comments such as: 'I have never seen the mental health policy', 'I can't answer this question because I do not know about it' and 'I am not sure as this is the first time speaking about this'. Many respondents attributed this lack of awareness due to the fact that policy decisions have been inadequately communicated at the grassroots level, with limited education for those responsible for implementing policy. As a senior psychiatric nurse at a regional hospital exclaimed:

> In regional level, when the policies are out, from my experience what happens is, you will be there, and you are told, or you get a letter that new directive or new policy is being implemented, and this is what you are expected to do. So before that implementation you will not be given any logistics, any information.

A second key barrier to policy implementation highlighted by the respondents was the limited consultation in the development of mental health policy. Many perceived policy-making in mental health to be a hierarchical process that excluded those at the grassroots, such as less senior health professionals and traditional or faith healers. As articulated by this senior psychiatric nurse:

> What happens is, the doctors, the specialist, the nurses, the experts, the directors are there. But that nurse who is not a director but is in a typical rural area, that nurse has got some information which if they were presented to this body, will be able to redraw or refocus their vision. But then these people are ignored.

It was widely acknowledged that it is difficult for implementers to accept and operationalize new policies when they have not been consulted from the outset. A psychiatric nurse in a general hospital pointed out that if mental health professionals are involved in developing a policy, then they will be more likely to be committed to implementing it:

> When it comes to policy making, sometimes they make the policies and they push it onto us. Even sometimes we are not aware of it, and before we realize the policy has been made and this is your copy. Then how do you implement it?

A third key barrier to policy implementation highlighted by the respondents was the limited intersectoral collaboration in mental health policy development. Respondents reported there is very little linkage between mental health policy and other related sectors, for example in education, the police force and the judiciary. It was recognised that without the collaboration of other sectors it would be difficult to implement mental health policy. Intersectoral collaboration, for example with the development sector, was seen to be essential in broadening the mental health agenda to address not just the medical aspects of mental disorders, but the socioeconomic components. One mental health NGO member remarked:

> I think the clearest deficiencies, or the most obvious deficiency, is a mental health policy that demonstrates linkages to socio-economic aspects of national development or national agenda.

This responded went on to recommend that mental health policy:

> . . . needs to be extended to include issues of governance, to include issues of the GPRS [Ghana Poverty Reduction Strategy], to include issues of education and what types of life skills education that people need to know as part of their personal development and goals.

In addition, various respondents argued that there is a general lack of reliable mental health research in Ghana, which in turn constrains the ability of research to inform policy. As a senior academic researcher lamented:

> I'm afraid to say this but there is not a whole lot of research going on in mental health. For one thing for lack of personnel we do not have the people who have the capacity to do the research in the area of mental health.

Besides problems around personnel capacity, having an insufficient research base was also attributed to a lack of local funds for research and thus a reliance on donor funding for research. As a mental health care administrator suggests:

> It [local funds] is woefully inadequate and thus the institutions have to get donor funding from our development partners and researches have to put in written proposals to look for funds to conduct this researches. The Ghana Health Services allocate only 5% of the health budget to research and out of that I don't know what proportion to be given to mental health.

Fifthly, the low priority of mental health and lack of political commitment was a repeated theme in participants' discussion around barriers to policy implementation. This view was expressed by both policy makers and mental health professionals, as this participant from the Department of Social Welfare (National Level) states:

> In Ghana generally there is lot of apathy … very few people are interested in mental health. I will tell you the truth: the attempt to formulate policy for mental health is always an afterthought in my view; it is not the priority in itself.

The lack of financial and human resources as well as widespread stigma, issues which will be expanded upon below, were discussed as additional barriers to policy implementation.

Several respondents suggested possible ways of overcoming such barriers to the implementation of mental health policy. One of the main recommendations was the need for increased political will from government. Numerous stakeholders remarked that policy could only be adequately implemented if 'government prioritizes mental health' and if there is 'increased commitment from those at the top'. In addition, revising the current mental health policy through widespread stakeholder consultation was also suggested as key way for ensuring that policy is adequately implemented. As one academic researcher emphasized:

> I would like to see really a debate of issues in the open by all stakeholders before any such policy is developed. We need to talk to all stakeholders, users, workers, relatives of users, and everybody in the society.

Finally, increased training and education on the policy was seen as essential for effective implementation, as indicated by this member of government:

> If you want to implement policies, if it is new, you must give the officers some kind of re-orientation about the whole policy, the officers must know what is expected of them. You don't just shove it down their throat if they don't know what the whole thing is all about.

Legislative limbo: current law outdated, new law still pending

At present, existing mental health legislation in Ghana is the Mental Health Decree of 1972. Numerous respondents in the health care sector emphasized that this law is outdated and inadequate, in particular in terms of its failure to promote, respect and protect the human rights for people with mental disorders. For example, when talking about the current mental health law, a senior pharmacist in the Ministry of Health argued:

> The current law is so outmoded. Every person, from all angles there is this discrimination so our law exists but it was not applied to the word. The rights of the mental patient are trampled on, they are all trample on, so we have come out with a new mental health law, we are fighting for it to be accepted in parliament.

As indicated by this last quotation, a new law has recently been drafted and is pending submission to parliament to be enacted into law. The development of the new mental health bill was praised by participants for extensive consultation with all stakeholders, from mental health professionals to care givers and community members, as in the words of this psychiatric specialist:

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

> also involved, so it a holistic something, holistic approach and participation is quite encouraging.

Several respondents also expressed immense optimism that the new law would be an important step forward in providing a mandate for improved quality of mental health care in Ghana and the protection of the human rights of those with mental health problems, as indicated by this senior psychiatric nurse:

> There is a great need to quickly pass new mental health law which has been placed before parliament within the ministry of health. We think that it should go to parliament to be passed because that law is so wide that it covers so many aspects ... realizing the importance of traditional healers especially in the care of these people and trying to address the way they should treat mental patience. If this law is actually come into being it will cover so many areas.

The hint of skepticism indicated at the end of this nurse's remark points to the frustration many mental health care professional expressed during the interviews about the current pending status of the new law. Indeed, the new legislation was formulated in 2006 and is still waiting to be passed. Until the new law is ratified, mental health legislation appears to be in a limbo, possessing somewhat of a non-existent status. This was seen to have many negative repercussions. As one accountant from a general hospital explained:

> We do not have the mental health law in the existence to work with right now. So once there is no law and the law is not there to protect them [the mentally ill] I mean any one at all can do anything from the doctor to the nurse to the general public. But if the law was in place ...

There was thus unanimous agreement amongst stakeholders who spoke about legislative issues that 'the new law needs to be passed, and quickly'.

Low levels of human and financial resources for mental health

Respondents from all levels and sectors of society alluded to the very low level of human and financial resources, with ubiquitous comments about the 'woefully inadequate', 'skeletal' and 'acute shortages' of mental health care professionals and funds dedicated to mental health. The limited amount of human and financial resources dedicated to mental health was attributed to two main factors. Firstly, stigma attached to mental health was suggested as a key factor limiting resources for mental health care:

> Most of our patients are stigmatized and that even affects the allocation of funds because people don't see how money that should be given to people who are insane.

Similarly, as indicated by a senior psychiatric nurse:

> ... nobody wants to be trained for psychiatry because of this stigma and then they say that there is no motivation. Do you understand? They think it's a dirty job, why should I go there?

Secondly, the low priority given to mental health in comparison to other health concerns was seen to contribute to inadequate available resources, as explained by this senior health researcher:

> ... malaria, diarrhoeal diseases, the pneumonia diseases, they take the chunk ... these ones have taken prominence, far more prominence over other disease issues.

Insufficient funding and people-power for mental health was seen as a major impediment to both policy implementation and the provision of quality mental health care, as vividly illustrated by the president of a mental health NGO in the country:

> Imagine a ward with about 160 patients with about four nurses, two nurses caring for such huge number of patients. What type of observation can you make? How many patients can you properly observe and write proper report about these patients so that it will help the psychiatrist or doctor to be able to determine what to do for this patient?

One senior nurse most succinctly captured suggestions put forward by so many other stakeholders when talking about human resources:

> ... what I will like to plead to the government is at least they should train more health professionals. So that all the district hospitals will have a psychiatric nurse.

Widespread stigma

Almost all respondents highlighted the widespread stigma and discrimination surrounding mental health in Ghana. The interviews were saturated with comments such as '... there is a whole lot of discrimination and stigma with mental health', 'mental health is also perceived with such negativity in Ghana' and 'mental health goes with such stigma'. The scope of mental health stigma and discrimination appears to be extremely wide, prevailing in the general community, amongst and towards mental health professionals and even extending to the psychiatric hospitals themselves. For example, a senior nurse educator explained:

> People see mentally ill patients as non-approachable, you know, you can't approach them, they are harmful and they don't want to get near them in the community.

Several respondents indicated that the psychiatric hospital itself is a major source of stigma, as one teacher explained:

> There are some places the stigma is there ... remains ... once you have seen the inside walls of the mental hospital, and you come back, I mean nothing about you is correct ...

The pervasive stigma towards mental health care professions was also widely acknowledged, as illustrated by this senior psychiatric nurse:

> It is a fact also that when you come to psychiatry, be you a doctor or a nurse, there is a big stigma attached to you. People also use you as the butt of their jokes.

Such widespread stigma appears to have many serious effects. The difficulties it poses for recruiting health professionals into psychiatry, the way in which it deters funding for mental health care, as well as the barriers it poses for policy implementation have already been touched upon. A number of other dire consequences of such stigma were mentioned by respondents. For example, widespread stigma surrounding mental illness means that people with disorders are frequently afraid to seek help,

leading to mental illness becoming a hidden problem, as this representative of the WHO at the national level remarked:

> People who are mentally ill are stigmatized, so most people wouldn't even come out to seek the necessary help that they need and to even take treatment which is available. And so ... the issue is more or less swept under carpet.

It was highlighted further that those patients who do seek help often remain admitted to the hospital for over-extended periods, as such stigma frequently results in relatives or caregivers abandoning the person at the psychiatric hospitals. As an accountant in a general hospital remarked:

> If a relative or somebody exhibits those characteristics, they abandon the person altogether either at the hospital or wherever. They don't want the person to come back into the family because they feel it's going to be a disgrace to them.

In addition, mental health stigma also leads to the discrimination of those with mental illness, particularly in the realm of employment, as explained by this counsellor:

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

Several respondents mentioned education as a means of addressing stigma towards mental health, as articulated by a national newspaper editor:

> ... they should educate the people to get away from that stigma and then people can walk straight into the psychiatric hospitals and then come out with their problems.

Dominance of psychiatric hospitals for mental health care

In Ghana, some moves towards de-centralization of mental health care have begun with the opening of psychiatric in-patient units in five of the 10 regional hospitals and the establishment of community psychiatric nursing services within 68 districts out of a total of 110. In addition, mental health has been integrated into all the Regional Health Management Teams and into those District Health Management Teams where community psychiatric nurses are in post. Initiatives through NGOs and other agencies to enhance the community detection of mental illness and provide treatment have met with some success and draw on the availability of public health workers at the sub-district level.

Despite these steps towards increasing decentralization, expanding community-based mental health services and integrating mental health into general health care, a key theme to emerge amongst a number of mental health care professionals was that mental health care in Ghana still remains concentrated in the psychiatric hospitals. For example, integration with primary care was still perceived to be inadequate, as in the words of this senior academic health researcher:

> ... I am not sure how successful we have been in terms of trying to make mental health care delivery as part of the normal health delivery system. ... The whole concept of having mental diseases totally off the general hospital ... has always been the practice.

In addition, it was emphasized that whilst there have been some efforts to de-centralise mental health into the regions, de-centralization is still highly inadequate. As an accountant from a psychiatric hospital argued:

> . . . we don't have enough treatment and counselling and centres in the country. I say so because most of the cases that come to the hospital are not supposed to come if we have these centres around if we talk out of stress for instance to me, this should not be a problem that should be brought to the psychiatric hospitals there is to me a minor case that can be handled at these centres if they were there.

Many mental health care professionals also suggested that decentralization has not been uniformly achieved across the country, with huge discrepancies between the north and the south. The population of the poorest parts of the country is therefore reached the least by mental health services. In the words of one senior psychiatrist:

> We have over the years tried to decentralize mental health which to some extent was successful in doing so. But it is not uniform in the various regions . . . they don't accord them uniform status.

Similarly, a senior health researcher argued:

> Where are the mental health facilities in this country? They are all based in the south; Pantang hospital, Ankaful and then Accra, three okay? The whole of central Ghana, the whole of northern Ghana there is no facility. So when people are sick you get them bundled, and then send them all the way down to one of these facilities at the coast.

Given these constraints facing Ghana's mental health care system, many respondents talked about the need to 'take psychiatry to the people' through developing community-based services, as one psychiatrist said:

> Community psychiatry should be improved so that we take psychiatry to the people in the villages and not wait for them to come to hospital . . . to my mind this is the most important thing.

Other respondents made more radical suggestion. One retired psychiatrist recommended for example that institutional care be de-emphasized:

> At this stage they have to think about de-emphasizing institutional care. We need to improve on the community care aspect and dismantle some of the large hospitals that we are unable to manage properly.

Widespread human rights abuses

Respondents' discussions around mental health were frequently situated within human rights discourses, with widespread talk about the abuses that the mentally ill experience in all mental health treatment facilities and institutions.

Many respondents raised concerns about the human rights abuses that can occur in the prayer camps and traditional shrines. Clinicians reported that persons with acute cases of mental illness are often chained, beaten and forced to engage in fasting. In describing the conditions at some prayer camps, one psychiatric nurse highlighted:

> The patients will be maybe chained to a tree and even the side where it's chained, sometimes they develop sores, sometimes gangrene, sometimes because of the struggle they have fractures and sometimes even in the hot sun they say that they want to exorcise the bad spirit to come out of the patient. So even in the sun they beat, they whip the patient for that spirit to come out and in the end some of the patients become exhausted and they die.

Some respondents suggested that the reason that these abuses continue to occur is because there is very little monitoring and regulation of the practices of traditional and faith healers, as illustrated by the words of this senior academic health researcher:

> The challenge is ensuring that that system is regulated because that is essential. We need to regulate whoever practices any profession. Unfortunately that system has not been well developed, so they go about and do their own things and nobody checks them.

Respondents' discussion around human rights and mental health did not relate solely to the practices of traditional and faith healers, but also to the more orthodox clinical-based setting. For example, in the psychiatric hospitals, seclusion and physical restraint were reported to occur as a result of the unavailability of sedating medication, or shortage of staff. Overcrowding in the psychiatric hospitals was indicated to lead to inhumane and unsanitary conditions. In the words of a WHO official:

> . . . I don't think you will walk into any other hospital and see someone lying on the floor, but here gradually maybe because of congestion and because you think the people are mentally ill, [sebe wabo dam: he might be mad] if he is lying on the floor somewhere, nobody cares.

Others, like this psychiatrist, attributed human rights abuses to the limited resources available at clinics:

> . . . people are trying to do their best to help people with mental illness, but when there is inadequacy and all those things set in, we don't intentionally try to violate people's rights. But when you keep someone in the mental hospital and you can't provide for the person, you then of course, you are violating that person's rights.

Respondents pointed out that the poor quality of care and human rights abuses in government facilities remain officially unchecked and few attempts are made to protect the rights of those with mental illnesses in such facilities. It was mentioned that there is no training in the protection of the human rights of patients in the inpatient psychiatric units and community residential facilities and that there is currently no national body to oversee regular inspections in mental health facilities, to review involuntary admission and discharge procedures, to review complaints investigation processes and to impose sanctions (e.g. withdraw accreditation, impose penalties or close facilities that persistently violate human rights).

There was widespread agreement amongst respondents that there is a need for 'increased monitoring and assessing the hospitals'. In addition, some respondents felt there should be some form of regulation for traditional and faith healers in order to prevent human rights abuses, as one academic researcher indicated: 'The challenge is ensuring that that system is regulated because that is essential'.

Discussion

This study provides qualitative insights into some of the key challenges facing Ghana's mental health care system. This study is novel in documenting these issues on a large, national scale and utilizing qualitative methodologies. For results from the quantitative component of the situation analysis see Ofori-Atta et al. (in press).

The results from this study revealed that mental health policy in Ghana has been inadequately executed, with a number of long-standing problems and structural difficulties impeding its implementation. One of the striking findings was that health care professionals and other stakeholders, such as the police and teachers, had no knowledge of mental health policy. It became evident that dissemination and training in mental health policy at all levels and across all sectors was insufficiently conducted, resulting in a lack of ownership amongst those responsible for implementation. The findings from this analysis also revealed that adequate and reliable data for the development of evidence-based mental health policy is seldom available, a problem in Ghana that has been reported elsewhere (WHO, 2005). This study also demonstrated that the low priority of mental health in Ghana and the lack of political commitment were key barriers to effective implementation of mental health policy. The top-down approach of mental health policy development was another dominant theme to emerge amongst participants, particular in the health care sector, with very narrow consultation taking for policy development.

In contrast to this vertical approach to policy development, one of the positive findings from the study was that the development of the new Mental Health Bill has been conducted with wide consultation with all stakeholders, not only at the level of 'experts', but also with those most affected by mental health policy: the users of mental health services and their carers and health professionals both within specialized services and within primary care. Despite this strength, the pending status of the new law appears to be creating much frustration and uncertainty amongst health care professionals, not to mention the legislative vacuum it is generating. Until it is passed by cabinet, despite being praised by many of the participants and widely considered to represent best practice (WHO, 2007), its potential will remain unrealized.

The results also indicated that Ghana's mental health system is plagued by inadequate human and financial resources, an insidious problem affecting many low-income African countries (Jacob et al., 2007). Stakeholders from all different levels provided detailed descriptions about the over-crowded and dilapidated nature of mental hospitals, the lack of sufficient medications and a paucity of mental health staff. Mental health care funding in Ghana is almost entirely from government, which is worrying given that the current mental health policy fails to mention the sources of funding for its objectives. Furthermore, despite recent increases in the numbers of psychiatric nurses being trained (Awenva et al., in press), respondents indicated that it remains difficult to attract highly qualified staff, particularly due to the widespread stigma surrounding mental health in Ghana.

Indeed, evidence from this study suggests that the scope of mental health stigma and discrimination is extremely wide, prevailing in the general community, amongst and towards mental professionals and even extending to the psychiatric hospitals themselves. This phenomenon is not unique to Ghana, but has been observed in many other African countries (Adewuya & Makanjuola, 2005). Evidence from this study suggests that such widespread stigma does not only influence the level of

human and financial resources in mental health in Ghana, but also has a number of other dire consequences. These include having a deleterious effect on people with mental disorders' willingness to access appropriate care and adhere to treatment regimes, as well as their ability to integrate into society and ultimately recover from their illness. These findings corroborate with other studies that have explored the consequences of mental health stigma (Rusch, Angermeyer, & Corrigan, 2005; Thornicraft, Brohan, Kassam, & Lewis-Holmes, 2008).

Pervasive stigma appears to be one of the many human rights abuses suffered by those with mental disorders in Ghana. Participants were particularly vocal about the widespread maltreatment that occurs at many mental health treatment facilities and institutions. Indeed, the harrowing human rights violations experienced by those with mental disorders has been reported in other studies in Ghana (Selby, 2008; Vinorkor, 2004) and globally (Dhanda & Narayan, 2007). A disquieting finding from this study was the limited structures that are in place in Ghana to monitor and regulate human rights abuses at both formal and informal facilities.

Evidence from this study also highlighted that mental health services are still marked by an over-reliance on of psychiatric hospitals for mental health care, a situation which has been documented in many other low-income countries in Africa (Desjarlais, Eisenberg, Good, & Kleinman, 1995). Respondents reported that there has been limited integration of mental health care within primary health care, only partial decentralization and insufficient development of community-based services. A strong theme to emerge amongst many respondents was that steps towards dismantling the hegemony of psychiatric hospitals for mental health care have been skewed in favour of the South, with an inequitable geographical spread of services. This is very worrying given that 45.4% of the population of the rural savannah areas of Ghana are estimated to be living in 'extreme poverty' as compared to 2% in the urban coastal areas (Government of Ghana, 2007).

The major strength of this study is its breadth, providing a very wide overview of the opinions over 120 individuals across Ghanaian society. The extensive scope of this study in turn means, however, that its depth is somewhat compromised. Most certainly, lacking depth is a limitation of the study, as the nuances and more subtle subjectivities are somewhat lost. An additional limitation of the study pertains to issues of sampling. The respondents were drawn largely from the southern part of Ghana due to the location of the capital city and the three state psychiatric hospitals in the south. This meant that fewer stakeholders were sampled from other regions in the country, including the three northern regions. With this said, some interviews were conducted in the district site of Kintampo, which is in the central region of Ghana. In addition, due to time and resource constraints very few users of mental health services and their families were interviewed. Such sampling biases are unfortunate as the views of the most vulnerable and marginalized are thus somewhat neglected.

Conclusion

This paper provides a comprehensive review of the key challenges facing mental health legislation, policy and service provision in Ghana, as perceived by a diverse array of stakeholders. The results from this study underscore the need for stakeholders at the macro and micro levels to start paying closer attention to the

mental health care needs of the country. From an epidemiological and social development perspective, Ghana's current mental health care system requires urgent transformation. This study offers insights into the key areas that need to be addressed at the legislative, policy and service delivery levels. Most certainly, addressing the burden of mental disorders presents enormous challenges within the context of limited resources. With this said, mental health services need to scaled-up to respond to unmet needs in ways that are culturally responsive and cost-effective within the budget of a low-income country. Enacting the current mental health bill and identifying strategies for overcoming the barriers to policy implementation will mark significant steps forward in the development of mental health care in Ghana. It is essential that Ghana, and other African countries, start recognizing mental health as a major public health concern.

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