From mental health policy development in Ghana to implementation: What are the barriers?

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Abstract

Objective: This paper identifies the key barriers to mental health policy implementation in Ghana and suggests ways of overcoming them. **Method:** The study used both quantitative and qualitative methods. Quantitatively, the WHO Mental Health Policy and Plan Checklist and the WHO Mental Health Legislation Checklist were employed to analyse the content of mental health policy, plans and legislation in Ghana. Qualitative data was gathered using in-depth interviews and focus group discussions with key stakeholders in mental health at the macro, meso and micro levels. These were used to identify barriers to the implementation of mental health policy, and steps to overcoming these. **Results:** Barriers to mental health policy implementation identified by participants include: low priority and lack of political commitment to mental health; limited human and financial resources; lack of intersectoral collaboration and consultation; inadequate policy dissemination; and an absence of research-based evidence to inform mental health policy. Suggested steps to overcoming the barriers include: revision of mental health policy and legislation; training and capacity development and wider consultation. **Conclusion:** These results call for well-articulated plans to address the barriers to the implementation of mental health policy in Ghana to reduce the burden associated with mental disorders.

Key Words: Mental health; Policy; Implementation; Barriers; Legislation

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Introduction

Addressing the burden of mental disorders presents enormous challenges at the clinical and public health levels, particularly in the context of limited resources.

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Globally, neuropsychiatric disorders including depression, schizophrenia, alcohol use disorders and bi-polar disorder account for a third of years lived with a disability among adults over 15.[1] Despite this, the World Health Organization (WHO) indicates that over 40% of countries do not have a mental health policy and over 30% have no mental health programmes.[2]

Over the last three decades a number of initiatives have been undertaken with the aim of improving mental health care within African countries. In 1988 and 1990 member

states in the WHO African Region adopted two resolutions to improve mental health services, with the expectation that African countries would develop mental health policies, programmes and plans.[3] However the WHO Mental Health Atlas revealed that by 2005 50% of countries of Sub-Saharan Africa still have no mental health policies to inform service delivery.[2] In 2001 the WHO World Health Report recommended ten key areas that need to be taken into consideration in developing effective mental health care delivery.[4] Unfortunately there has been little progress towards implementing these recommendations and mental health care remains a low priority in many African countries.[5] Over 40% of African countries have no community mental health provision and care remains concentrated in psychiatric hospitals.[2]

Therefore a key question is: Why is it that, despite the wide dissemination of such recommendations for improving mental health care delivery, progress in the implementation of mental health policy still remains slow in Sub-Saharan Africa? A qualitative survey of a selected group of international experts in mental health identified some barriers to mental health service implementation in low- and middle-income countries. These included insufficient funding for mental health services; mental health resources centralized in and near big cities and in large institutions; complexities of integrating mental health effectively in primary care; low numbers and limited types of health workers trained and supervised in mental health care, and mental health leaders often deficient in public health skills and experience.[6] In Africa, the World Psychiatric Association suggests that lack of awareness of the burden of mental illness, the lack of a reliable information system, insufficient human and financial resources, and an absence of mental health policies, are among the factors which impede the development of mental health programmes.[7] Another suggestion is that mental health issues are often given a low priority by policy-makers in the context of competing health needs.[3,8] Whilst health is inadequately funded in low- and middle-income countries, compared to other areas mental health receives even less funding. Nearly 70% of African countries spend less than 1% of their health budget on mental health.[9]

Mental health policy in Ghana was developed in 1994 and revised in the year 2000. The policy set out twelve objectives including de-centralisation of mental health services, establishment of a national mental health co-ordinating group, the training of mental health professionals, including specialist community mental health workers, provision of transportation for community mental health workers, raising mental health awareness for the family and community, and providing for community rehabilitation of the mentally ill. Unfortunately in the 14 years since the policy was drafted, none of the provisions of the policy has been fully implemented. Whilst there have been some moves towards de-centralization through the provision of psychiatric beds in five of the ten regional hospitals, and an increase in the number of mental health professionals trained, these strategies have only gone some way to improving mental health care delivery in Ghana. Psychiatric care remains largely centralized within mental hospitals in the south, and is unevenly spread across the rest of the country, with the northern areas the most neglected. The number of mental health professionals is far below that needed to provide even a basic level of care, and human rights abuses in informal treatment centres such as shrines and prayer camps remain widespread.

To date, little research has been conducted within sub-Saharan Africa to identify the barriers encountered when attempting to implement mental health policy and suggested solutions to overcome these barriers. The current paper aims to explore the barriers to mental health policy implementation in a low-income African country by reporting aspects of a situational analysis of mental health policy development and implementation in Ghana.

The situational analysis was conducted in a context of a wider international study of mental health policy development and implementation in four African countries; Ghana, Uganda, South Africa and Zambia.[5] The study, The Mental Health and Poverty Project (MHaPP), set out to investigate the mental health policy interventions that are required to break the vicious cycle of poverty and mental ill-health, in order to generate lessons for the improvement of health care delivery in low- and middle-income countries.

Method

The study location

The study was conducted in five of the ten regions of Ghana: Greater Accra, Central, Ashanti, Brong Ahafo and Northern regions, at the national (macro), regional (meso) and district (micro) level. Kintampo North District was selected as a demonstration site at the district level, since it is a rural area, far from the capital and the psychiatric hospitals. At the time of research there was no specialized psychiatric provision in the district.

Data collection

The study used both quantitative and qualitative methods of data collection. Data collection took place between September 2006 and August 2007.

Instruments

The WHO Mental Health Policy and Plan Checklist and WHO Mental Health Legislation Checklist were used to assess the content of mental health policy, plans and legislation in Ghana.[10,11] These checklists were designed to assess the content and process of developing mental health legislation, policy and plans according to a number of criteria. The checklists were completed by a committee consisting of the Co-Principal Investigator of the Ghana site of the MHaPP, a Ministry of Health representative, the MHaPP Research Officer for Ghana, the National Coordinator of Community Psychiatric Nurses, and the Deputy and the Director of Nursing Services, Accra Psychiatric Hospital.

Qualitative data

In-depth interviews and focus group discussions with key stakeholders were conducted at the macro, meso and micro levels to provide an understanding of the context and

process of mental health policy development and implementation in Ghana. Respondents were purposively sampled from amongst the major stakeholders in mental health in Ghana. These included mental health professionals, policy makers, academics, administrators, health researchers, the media, religious leaders, traditional and faith healers and users of psychiatric services. For non-English speakers, interview and focus group guides were translated into Twi, the local language in the study district. 122 respondents participated in semi-structured interviews (SSIs) and focus group discussions (FGDs), with 58 SSIs and 1 FGD conducted at the macro/meso level, and 23 SSIs and 6 FGDs at the micro level. The number of participants for each FGD ranged from five to nine. Out of 23 SSIs conducted at the micro level, 16 were conducted in English and 7 in Twi, 6 FGDs were conducted in English, and 1 was conducted in Twi. All interviews were digitally recorded with the participants' consent. However, four respondents refused consent for their interviews to be recorded and therefore written notes were taken instead. All interviews were transcribed verbatim. Interviews conducted in Twi were first transcribed in Twi and then translated into English. All transcripts were entered into Nvivo 7 which was used for analysis.

Data analysis

A framework analysis approach was adopted in which certain themes were agreed upon by investigators from the four study countries, through a process of iteration, until a single framework was agreed upon.[12] These themes were based on the objectives of the study. Transcripts were coded on the basis of these themes, with additional themes added to the coding framework as determined by the data, in order to reflect issues specific to Ghana.

Research Ethics

The research protocol was submitted to the Scientific Review Committee of Kintampo Health Research Centre (KHRC) for scrutiny of the scientific merit of the study. Ethical approval was granted by the Ghana Health Service Ethics Committee at the national level and the Institutional Ethics Board at KHRC. Information sheets containing essential information about the study and the implications of participation were submitted to all participants. Participants were requested to sign a consent form to indicate their willingness to participate in the study. Participants who were unable to read and write had a witness to 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 have been removed in order to protect their confidentiality.

Results

Several major barriers to mental health policy implementation were identified, and will be described and illustrated with excerpts from interview transcripts These included the low priority of mental health, a lack of political will, dwindling human resource capacity, no commitment to funding in policy, insufficient consultation prior to policy formulation, limited awareness of mental health policy among those responsible for its implementation, and lack of an evidence base for policy formulation.

Low priority of mental health

Mental health was perceived by many participants to be of low priority to the Ministry of Health in Ghana and to society at large. It was felt that there is a lack of interest in and understanding about mental health issues at the government level. This view was expressed by both policy makers and mental health professionals:

> *'I think the whole issue of mental health is not looked at more critically like they look at maternal health and stuff like that. The whole issue of mental health is not an attractive place where people provide money into'*
> (Director of Department, Ghana Health Service)

> *'….people normally say everybody has a little mental problem but unfortunately it looks like our health policies don't recognize that much, and for which reason we deal with other diseases rather than mental health. And if you could get into our mental hospitals and look at the structure, the facilities, the infrastructure itself, and even the number of doctors and nurses that manage those places, then you realize that government policies do not match effectively towards mental health.'*
> (Director, Department of Criminal Justice)

A repeated theme among participants was that due to the lack of political commitment and inadequate allocation of resources, the formulation of mental health policy has always been an 'afterthought':

> *'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.'*
> (Department of Social Welfare, National Level)

Mental health professionals were unanimous about the low priority given to mental health in terms of the neglect of treatment facilities, the shortage of mental health professionals, lack of support from other health disciplines, and the unreliable supply of essential medication:

> *'Look at the situation in our mental health hospitals. The facilities are running down, there is shortage of nurses. The way the Accra mental health hospital is run down even, when you look at the resources that go into mental health, we literally have to beg to be given what in my view represent the minimum requirements for us to work. We have only one doctor and the work load here is heavy. The pharmacists, we have to beg them literally for*

them to look at our face. Most of our drugs come and they stay there, expire without them informing us. We will run short of drugs and they will not be replenished unless we go to beg. As I speak now, we have run out of chlorpromazine. How can you run a teaching hospital like a centre of excellence when we lack such a basic thing like chlorpromazine?'
(Senior Academic Researcher)

Human resources in mental health

Many respondents discussed the very low level of human resources in mental health, from psychiatrists to nurses and other health professionals as impeding the provision of quality mental health care, as graphically illustrated by this participant:

'Imagine a ward with about one hundred and sixty 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?'
(President, Mental Health NGO)

The inadequate numbers of community psychiatric nurses (CPNs) and the virtual absence of allied mental health professionals such as psychologists, occupational therapists, and psychiatric social workers within mental health services were seen by some respondents to restrict the provision of mental health care to the administration of psychotropic drugs, rather than psychosocial, preventive or rehabilitative interventions:

'….the preventive aspect of mental health is the work of the community psychiatric nurses, apart from seeing to rehabilitation after treatment, educating people about drug abuse, and releasing of stress and things like that, but they're so few in the system.'
(Senior Nurse Educator, Regional Level)

'Our system is such that we are trying to use community psychiatric nurses to trace the patient and try to see to their medication in the home, but that is not enough. The social aspect… our ancestors left us a system where we should have followed up with the social aspect, rehabilitate the patient, see to the patient that the patient is established in society. Now the whole system has fizzled down to our use of the institution and drugs, stabilizing the patient, sending the patient home and then we sit down and wait for the patient to come back.'
(Pharmacist, Psychiatric Hospital)

Financing mental health

Several respondents argued that insufficient funding for mental health was an impediment to mental health policy implementation. Data from the WHO Policy Checklist revealed that the 1994 Mental Health Policy contains no funding provisions. The reviewers concluded that 'There is a lot of lip service in terms of commitment to implement the mental health strategies and plans. Mental health appears too expensive for the policy makers to implement.' A psychiatrist confirmed this in stating that: '….resources are not given adequately for running of services both at the institutional level and at the community level.' This same psychiatrist suggested that the stigma attached to mental health affected the funding of 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 sane to be given to the insane who they feel can not contribute to society.'
(Senior Psychiatrist, Psychiatric Hospital)

It was also felt that other health concerns tended to displace mental health in terms of funding priorities:

'….malaria, diarrhoeal diseases, the pneumonia diseases, they take the chunk, because when you go to the records in the hospitals, health facilities and the rest, they are most of the time the top five diseases that report. So these ones have taken prominence, far more prominence over other disease issues.'
(Senior Health Researcher)

Another difficulty highlighted was that there is no dedicated budget for mental health at the regional and district levels where mental health care is provided within primary health care. Given the low priority of mental health, and the pressure on resources, the ability to plan for the care of the mentally ill at the primary care level is severely constrained, as this nurse commented:

'We just do within our reach, whatever we can do to help the people. The budget is not enough and you cannot come out with specific programme. That is the limitation because we don't have an earmark budget. Even what we have, it is too small.'
(Senior Public Health Nurse, District Level)

Consultation in policy formulation

Results from the WHO Policy Checklist revealed a lack of consultation in the development of mental health policy. No consultation with representatives from the relevant stakeholders in the Ministry of Health such as the departments with responsibility for human resource development, pharmaceuticals, child health and HIV/AIDS, or the Ministries of Finance, Education, Social Welfare, or Criminal Justice was undertaken. Users of mental health services and their families, and the private sector and NGOs were also excluded from the consultation process.

Many mental health professionals interviewed confirmed this lack of consultation in policy development, particularly in the rural areas. Some perceived policy-making in mental health to be a hierarchical process which excluded those at the grassroots, such as less senior health professionals, and traditional or faith healers, as illustrated by this psychiatric nurse:

> *'What happens is, if policy is to be drawn in psychiatry, we know 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 representing the government as regard to psychiatric services, that nurse has got some information, solutions or some problems which if they were presented to this body, will be able to achieve and redraw or refocus their vision. But then these people are ignored at all… even it could be those people who have been treating our patients in church houses and the shrine, let's go and ask them why the people come there in the first place? But then we always think that these are experts - the specialist, the administrators, but these people are always in the cities.''*
> (Senior Psychiatric Nurse, Regional Hospital)

This perception was confirmed by a psychiatrist who admitted that mental health policy formulation was a 'vertical' process which did reach down to implementers at the lower levels:

> *'Mostly, it is only mental health providers who are involved in the development of the policies and we involve heads of the units but it doesn't transfer to the whole other non-mental health providers. It is more within the…. it is more like a vertical consultation more than involving all the other stakeholders. But then this is usually corrected by the meetings that we have with the management. We have management meetings which used to be twice a year. It is then that we explain some of the policies to management. But that doesn't go down to the implementers at the lower levels.'*
> (Senior psychiatrist, National Level)

Another psychiatric nurse 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:

> *''... but 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? Because when you are part of the planning you make sure for the policy to succeed, you make sure you implement it very well.''*
> (Senior Nurse, Psychiatric Hospital)

Knowledge and education

Several respondents indicated that mental health policy is not being implemented in part due to lack of awareness of the policy by mental health professionals, primary health care workers, other professional groups and the general public, and the absence of training in policy implementation as described by these participants:

> *'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, some of them, the problems, you understand? There is not much education on mental health nursing to the ordinary Ghanaian, you understand? And even policy implementers, people are not really well informed about mental health programmes. So you find out that even though the policy is there, people will find it difficult to implement them.'*
> (Psychiatric specialist, National Level)

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

This nurse described how policy implementation often took a top-down approach, in which there were no resources provided to facilitate policy implementation at the regional and district levels:

> *'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 education'*
> (Senior Psychiatric Nurse, Regional Hospital)

The failure to adequately disseminate mental health policy was evidenced at the district level where most respondents demonstrated very limited knowledge of the provisions of mental health policy. Most of the respondents within the health service, the police, education and social welfare said they had no idea of the existence of these documents, let alone awareness of the provisions of mental health policy and their role in implementation.

Evidence base for policy formulation

Some respondents identified the absence of an evidence base for mental health policy formulation. The WHO Policy Checklist revealed that no research was undertaken to

inform the development of mental health policy, and the main sources of data consulted in policy formulation were student theses and data from the three psychiatric hospitals.

This participant noted the lack of efficiency and reliability in gathering data on mental health in Ghana which impairs the ability to argue for greater priority for mental health:

> *…we don't as yet see a database, our record department itself even is not on its feet. Figures coming out from those places can easily be challenged. We have the three institutions. We don't have coordinated records department. The activities are not well coordinated, we have not built the base for making argument from that angle.'*
> (Pharmacist, Psychiatric Hospital)

One psychiatric nurse pointed out that even when data was collected it did not seem to influence policy as resources remained far below what was indicated by the data:

> *'….looking at our data, the number of patients that pass through our hand every week, every month and quarterly, you can find out that if they have been using the evidence here they will give us more doctors, more psychologists…'.*
> (Senior Nurse, Psychiatric Hospital)

A researcher noted that the lack of research in mental health constrained the ability of research to influence policy. He noted the lack of research capacity within Ghana for mental health:

> *'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.'*
> (Senior Academic Researcher)

Overcoming the barriers

Several respondents suggested possible ways to overcoming such barriers to the implementation of mental health policy. These include the revision of mental health policy and legislation, human resource capacity development, and greater collaboration in developing mental health policy.

Revision of mental health policy and legislation

Over the last ten years there has been an acknowledged need to develop new mental health legislation in Ghana. The current 1972 legislation is outdated and does not accord with World Health Organization standards. An attempt was first made to revise Ghana's mental health legislation in 1996. However, publication of the World Health Report on mental health in 2001 gave renewed impetus to the movement for mental health law reform.[4] In 2004, a committee was convened to review the existing mental health legislation in Ghana utilizing the WHO Checklist on Mental Health Legislation.[11] The committee consisted of psychiatrists, psychologists and legal representatives supported by an external team of consultants from WHO Department of Mental Health. A new mental health bill was developed however it is still waiting to be passed into legislation.

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:

> *'….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'*
> (Psychiatric Specialist, Regional Level)

Several respondents within the mental health field expressed a strong desire for the draft Mental Health bill to be passed into law so as to improve mental health care. There was optimism that the new legislation would promote de-centralization and community mental health care, regulate traditional and faith-based healing practices, and promote and protect the rights of the mentally ill. This respondent noted that there is the need for a legal mandate to enforce policy implementation which is absent from current mental health policy:

> *'The policies were approved at the ministry level, they were not policies backed by law. So it's more like a gentleman's policy which from time to time we teased some out and implemented.'*
> (Senior Psychiatrist, National level)

However, some respondents were skeptical as to whether there was sufficient political will and financial commitment to implement the bill when passed into law.

Training and capacity development

Respondents stressed the need to train more health professionals in mental health in order to expand the provision of community care:

> *'….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'*
> (Senior Nurse, District Level)

This psychologist also suggested the need for in-service training to update the skills of mental health professionals, and for the provision of adequate resources for them to carry out their work effectively, particularly at the community level:

> *'….if you are talking in terms of knowledge, they need regular in-service training. They need to know much about the new drugs that are coming into the system [….] they need to be resourced in terms of funds, vehicles, in terms of a lot of things, so that they can move out to reach people in the community who are having the problems there.'*
> (Senior Academic Psychologist)

Consultation

Wide consultation was seen by interview participants as improving the commitment of stakeholders to the development of the policy through to its implementation, as expressed by this researcher:

> *'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.'*
> (Senior Academic Researcher)

A psychiatric nurse also emphasized the need for consultation with health workers responsible for policy implementation:

> *'So before this document comes in and gives you the order that you should implement it, there should be some kind of workshops so that people will meet each other in a think tank situation where you know that this is what they are going to implement and from what I see this is the problem which we are going to face……Now if all those people who are part of the policy…. implementation of the policy undergo such workshops over time and they are allowed to express themselves freely: ''What do you see as a problem? What do you see as the way forward?'', probably an amendment or modification could be done on the policy which is going to be implemented '*
> (Senior Psychiatric Nurse, Regional Hospital)

Discussion

In Ghana, poor mental health service delivery is perceived to be the result of uneven mental health policy implementation. As this study reveals, a number of long-standing problems and structural difficulties for the implementation of mental health policies in Ghana remain. There is a need to identify strategies for overcoming these barriers in line with recommended guidelines for the implementation of mental health policy.[13]

This study demonstrates the low priority of mental health in Ghana and the lack of political commitment to the implementation of mental health implementation. Advocacy can play an important role in highlighting the needs of those with mental disorders.[8] Groups such as service users, mental health professionals, researchers and NGOs can work together to exert pressure to put mental health on the political agenda.[3]

WHO suggests the need to develop a national advisory body to government on the implementation of mental health policies and the development of mental health services.[10] Such a group could play a role in reviewing, monitoring and evaluating mental health policies and programmes. The committee could also collaborate with other sectors such as the Ministries of Education, Justice, Local Government, Social Welfare, and development agencies and donors to raise awareness of the impact of mental disorders and the need to consider mental health when developing their own policies and programmes.

As this study reveals, the quality and availability of mental health care in Ghana is severely constrained by the paucity of mental health professionals and limited opportunities for professional development. The lack of professionals with training in psychosocial interventions means that treatment remains focused on psychotropic medication and there is very limited provision of psychosocial care and rehabilitation. Despite a recent increase in the numbers of psychiatric nurses being trained, it remains difficult to attract highly qualified staff to the rural areas where the need is the greatest. Previous initiatives in community mental health in Ghana have suggested that there is the potential to enhance the skills of lower level community health workers such as community nurses, technical officers and volunteers to detect and refer cases of mental illness.[14] The Ministry of Health has recently agreed to train two new cadres of community mental health workers, however there will remain the challenge of posting such workers to the rural areas. There is also a need to provide effective support and supervision for mental health professionals and primary care workers, as well as opportunities for ongoing training, in order to maintain a high standard of care.

Adequate funding and logistical support across all sectors is essential for effective execution of mental health policy yet respondents identified a lack of finance and resources for mental health policy implementation in Ghana. Indeed the current mental health policy fails to mention the sources of funding for its objectives. Thus most community psychiatric nurses, to take one example, are unable to carry out effective community outreach due to a lack of transport. Since most funding for mental health is absorbed by the psychiatric hospitals in Ghana, it is hoped that de-institutionalization would release some funds for primary care (Ofori-Atta, Read and Doku, under review). However in order for policy to move beyond 'lip-service' to the ideals of community mental health care as claimed by some respondents, there is a need for policy directives to be adequately costed, and for funding to match policy objectives.

Respondents recognized that mental health policy formulation in Ghana has tended to follow a top-down approach. There was little consultation in both the development and implementation of current mental health policy. Yet it was recognized that broader consultation across all stakeholders, particularly with health workers at the district level, is vital for the successful implementation of mental health policy. As argued by participants in this study, future mental health policy should follow the example of the Mental Health Bill in conducting wide

consultation with all stakeholders, not only at the level of 'experts', but 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.

It is striking that health professionals and other stakeholders interviewed in this study, such as the police and teachers, had no knowledge of mental health policy. Dissemination and training in mental health policy at all levels and across all sectors is essential for successful implementation of policy, and a sense of ownership amongst those responsible for implementation. In addition to front-line health workers, this should include the police, prisons, schools, social welfare departments, the courts, and all other agencies which in the course of their duties have direct or indirect contact with people with mental disorders.

This study shows that adequate and reliable data for the development of evidence-based mental health policy is seldom available. Reliable, comprehensive and accurate data on the incidence of mental disorders, the numbers of people attending both specialist treatment centres and primary care, and the impact of mental disorders on the individual and family, can provide a sound basis for arguing for increased commitment and resources for mental health, and for planning effectively for mental health care delivery.[15] Strengthening the evidence base through research in mental health and the development of an efficient and comprehensive mental health information system is therefore an important first step for Ghana in developing mental health policies which address those areas most in need.

There was widespread support among participants for the Mental Health Bill. The passing of this legislation would provide extensive legal backing for the implementation of mental health policy. Unfortunately to date the Bill has not been passed despite intensive lobbying. However it remains a key priority for the future of mental health in Ghana that this legislation, which has been praised for representing best practice in such areas as the extent of consultation and in protecting human rights, is passed.[16] The Bill is an essential first step towards revising mental health policy, and would demonstrate a political commitment towards the improvement of mental health care in Ghana. However as participants caution, there is a need to develop policies and plans, including the provision of funding, which will ensure that the new legislation can be effectively implemented.

Conclusion

This study reveals that Mental Health Policy in Ghana is perceived as outmoded and largely unimplemented. Barriers to the effective implementation of mental health policy identified by respondents included the low priority of mental health, inadequate human resources and finance, lack of consultation in policy formulation, a failure to effectively disseminate policy, and the absence of an evidence base for policy directives. The much-anticipated passing of the Mental Health Bill in Ghana will provide the impetus for the development of new mental health policy. New concepts for a revised policy must include a rights-based perspective and promote best practices in mental health, in line with the proposed legislation. However it is essential that new mental health policy does not follow the path of previous policy by providing both the financing and resources for its successful implementation, and ensuring that all stakeholders including users, carers, health workers and other sectors such as social welfare and the police, are consulted throughout the policy development process. In addition, it is vital that those responsible for implementation at the frontline of health service delivery are provided with the necessary training and resources to implement the policy. Only then can mental health policy effectively bring about an improvement in service provision for one of the most vulnerable and neglected groups in Ghanaian society.

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References

1. *WHO. Global Burden of Disease 2004 Update. Geneva: World Health Organization, 2008.*
2. *WHO. Mental Health Atlas. Geneva: World Health Organization, 2005.*
3. *Gureje O, Alem A. Mental health policy development in Africa. Bulletin of the World Health Organisation 2000;78(4):475-482.*
4. *WHO. The World Health Report 2001: Mental Health: New Understanding, New Hope. Geneva: World Health Organization, 2001.*
5. *Flisher AJ, Lund C, Funk M, et al. Mental health policy development and implementation in four African countries. Journal of Health Psychology 2007;12(3):505-516.*
6. *Saraceno B, van Ommeren M, Batniji R, et al. Barriers to improvement of mental health services in low-income and middle-income countries. The Lancet 2007;370(9593):1164-1174.*
7. *Okasha A. Mental health in Africa: The role of the WPA. World Psychiatry 2002;1(1):32-35.*
8. *WHO. Mental Health Policy Project: Executive Summary. Policy and Service Guidance Package. Geneva: World Health Organization, 2001.*
9. *Jacob KS, Sharan P, Mirza I, et al. Mental health systems in countries: where are we now? The Lancet 2007;370:1061-1077.*
10. *WHO. Monitoring and Evaluation of Mental Health Policies and Plans. Mental Health Policy and Service Guidance Package. Geneva: World Health Organization, 2007.*
11. *WHO. WHO Resource Book on Mental Health, Human Rights and Legislation. Geneva: World Health Organization, 2005.*
12. *Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG, eds. Analysing Qualitative Data. London: Routledge, 1994: 173-194.*
13. *WHO. Mental Health Policy, Plans and Programmes. Mental Health Policy and Service Guidance Package. Geneva: World Health Organization, 2005.*
14. *WHO. Nations for Mental Health: Final Report. Geneva: World Health Organization, Mental Health Policy and Service Development, Department of Mental Health and Substance Dependence, 2002.*
15. *WHO. Mental Health Information Systems. Mental Health Policy and Service Guidance Package. Geneva: World Health Organization, 2005.*
16. *WHO. Ghana Country Summary. Mental Health Improvement for Nations Development (MIND). Geneva: WHO, Department of Mental Health and Substance Abuse, 2007.*