A reflection on Ghana's mental health system

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In recent years, the delivery of mental health services in Ghana has expanded substantially, especially since the passing of the Mental Health Act in 2012. In this article, I reflect on my experience as a visiting psychiatry resident in August 2018 at 2 Ghanaian hospitals located in Accra and Navrongo. Evident strengths of the mental health system were family support for patients and the scope of psychiatrists, while the most prominent weakness was the inadequate funding. As treatment of mental illness expands, more funding, psychiatrists, and mental health workers will be critical for the continued success of Ghana's mental health system.

Psychiatric treatment in Ghana

Ghana has a population of approximately 28 million people, yet the country has an estimated 18 to 25 psychiatrists, up from 11 psychiatrists in 2011.[1-3] Compared with the United States, which has 10.54 psychiatrists per 100,000 people (approximately 1 psychiatrist per 9,500 people), Ghana has .058 psychiatrists per 100,000 people (approximately 1 psychiatrist per 1.7 million people).[4] In Ghana, most psychiatric care is delivered by mental health nurses, community mental health officers (CMHOs), and clinical psychiatric officers; supervision by psychiatrists is limited.[3] Due to low public awareness, a scarcity of clinicians, and limited access to diagnostic services and medications, individuals with psychiatric illness in Ghana are often stigmatized, undertreated, and mistreated. To address this, in March 2012, Ghana passed Mental Health Act 846, which established a mental health commission and outlined protections for individuals with mental health needs.[5] Since then, the number of people seeking treatment and the number of clinicians have expanded, but there are still significant challenges, such as a lack of funding for medications and facilities, and limited clinicians.[6]

During my last year of psychiatry residency at Mount Sinai Hospital in New York, I spent several weeks in Ghana at 2 institutions, observing and supervising the provision of psychiatric services. This was my first experience with the country's health care system; therefore, my objectives were to:

- assess the current state of psychiatric services through observation and interviews with clinical staff
- provide instruction to clinicians in areas of need.

Two-thirds of my time was spent at the Accra Psychiatric Hospital, 1 of only 3 psychiatric hospitals in Ghana, all of which are located in the southern region of the country. The remainder of my time was spent at the Navrongo War Memorial Hospital in Ghana's Northern Region.

The Accra Psychiatric Hospital is a sprawling complex near the center of the capital

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city. Every morning I walked through a large outdoor waiting area to the examination room, which was filled with at least 30 patients by 9 AM. What was most striking was the volume of patients seen by the physicians for medication management within a typical 6-hour period. On average, a physician saw 20 to 25 patients a day, although it would sometimes increase to 30 to 40 patients. Many follow-up visits lasted <10 minutes, but visits could easily last 30 minutes or longer if necessary when there had been significant interval changes, or the physician was providing psychoeducation to the patient and his/her family. There seemed to be no rush by the clinicians, and patients seemed to maintain their patience. One factor that contributed to the efficiency was that notes were typically handwritten in real time and contained only the patient's pertinent clinical history, assessment, and treatment plan, and lacked the extraneous templated information that now makes many medical charts in the United States more complex. However, paper charts have limitations; such records cannot be accessed remotely and simultaneously, and if a chart is lost, there is no back-up or way to recover lost information.

Navrongo War Memorial Hospital. There are no practicing psychiatrists in the northern region of the country; therefore, all mental health care is delivered by mental health nurses and CMHOs. CMHOs have 1 year of training plus a minimum of 2 years of service. They focus on identifying psychiatric cases in the community and coordinating treatment. Nurses have prescribing rights. A psychiatrist should be scheduled to visit the various districts in the region every 6 months to provide supervision, but this is not always feasible.

When I visited, I was the only psychiatrist who had been to this hospital in more than 1 year. During my time there, I reviewed the treatment protocols and gave lectures on the management of psychiatric emergencies and motivational interviewing, because addiction to alcohol and tramadol are 2 of the most pressing mental health problems in the country.[7] I also saw patients with nurses, and supervised them on their assessment and treatment.

In Ghana, psychiatric services are often delivered using the community mental health model, in which many patients are visited in their homes. One morning, we went to a prayer camp to see if there were any individuals who would benefit from psychiatric services. There were no cases that day, but during the visit I sat under a tree where a few years before it was not uncommon to find a person who was psychotic or agitated chained to the tree. Several years of outreach by the local nurses has resulted in the camp leaders better recognizing mental illness early and contacting the nurses, as opposed to locking a person in chains for an extended period.

On one occasion, we answered a crisis call where a person experiencing a psychotic episode had locked himself in his house. The team talked with the individual through a locked screen door for 30 minutes, after which he eventually came out of the home to speak with us. A few days later, the patient accepted fluphenazine decanoate injection at his home. Two weeks later, he came to the outpatient clinic to continue treatment. Four months later, the patient was still in treatment and had started an apprenticeship for repairing cars.

As I was walking out of the hospital on my last day, I was called back to see a woman with a seizure who had been brought to the hospital. Unfortunately, there was no more diazepam in stock with which to treat her. This event highlighted the lack of resources available in this setting.

3 Take-home messages

My experience at both hospitals led me to reflect on 3 important factors impacting the mental health system in Ghana:

Family support. For at least 80% of appointments, patients were accompanied by family members or friends. The family

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Ghana has a population of approximately 28 million people, and an estimated 18 to 25 psychiatrists

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hierarchy is still dominant in the Ghanaian culture, and clinicians often need the buy-in of the family, especially when financial support is required. More often than not, families enhanced patients' treatment, but in some instances, they were a barrier.

The types of cases. Most of the patients coming to both hospitals had diagnoses of bipolar disorder, schizophrenia, substance use disorder, or epilepsy. My impression was that patients or family members sought treatment for disorders that were conspicuous. I saw <5 cases of depression or anxiety. I wonder if this was because:

- patients with these disorders were referred to psychologists
- patients sought out faith-based treatment
- there was a lower incidence of these disorders, or these disorders were detected less frequently.

Inadequate funding. Despite the clinicians' astute observations and diagnoses, they faced challenges, including a lack of access to medications because pharmacies were out of stock, or the patient or hospital could not afford the medication. At times, these challenges resulted in patients admitted to the hospital not receiving medications. When Mental Health Act 846 was implemented, it was widely purported that mental health care would be available to everyone, but the funding mechanism was not firmly established.[8,9] Currently, laboratory workup, mental health treatment, and medications are not covered by health insurance, and government funding for mental health is insufficient. Therefore, in most areas, the entire cost burden of psychiatric care falls on patients and their families, or on hospitals.

Making progress despite barriers

In her inaugural address, former American Psychiatric Association President Altha J. Stewart, MD, named expanding the organization's work in global mental health as one of her 3 primary goals.[10] There are several means by which American psychiatrists can support the work of psychiatrists in Ghana and elsewhere. One way is by helping the mental health commission and other entities within the country petition the government and health insurance companies to expand coverage for mental health services. Teleconferencing, in which psychiatrists in Ghana or other parts of the world provide supervision to mid-level clinicians, has been piloted in other countries such as Liberia and could be implemented to address the critical shortages of psychiatrists in certain regions.[11]

In the past 7 years, Ghana has made significant strides in destigmatizing mental illness, and as a result more individuals are seeking treatment and more clinicians at all levels are being trained. Despite significant barriers, physicians, nurses, and other mental health workers deliver empathic and evidence-based treatment in a manner that defies the mental health system's current limitations.

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