

Improving barriers to child and adolescent mental health outcomes in Ghana: a narrative review

by

Truelove Twumasi-Afriyie

B.A., Brock University, 2013

PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF

MASTER OF PUBLIC HEALTH (GLOBAL HEALTH)

In the

Faculty of Health Sciences

© Truelove Twumasi-Afriyie 2016

SIMON FRASER UNIVERSITY

Summer 2016

All rights reserved.

However, in accordance with the *Copyright Act of Canada*, this work may be reproduced, without authorization, under the conditions for Fair Dealing. Therefore, limited reproduction of this work for the purposes of private study, research, education, satire, parody, criticism, review and news reporting is likely to be in accordance with the law, particularly if cited appropriately.

Approval

Name: Truelove Twumasi-Afriyie
Degree: Master of Public Health
Title: *Improving barriers to child and adolescent mental health outcomes in Ghana: a narrative review*

Examining Committee: **Chair:** Kelley Lee

Kelley Lee
Senior Supervisor
Professor

Marina Morrow
Second Reader
Professor

Date Defended/Approved: July 26, 2016

Abstract

There is increasing evidence that suggests that mental health problems affect 10-20 per cent of children and adolescents worldwide. Despite the increasing contribution of mental health to the total burden of disease and the impacts of mental disorders, policies, plans and programs to address mental health has been given less attention, particularly in low resource poor settings. Ghana is one such setting. Addressing the burden of poor mental health poses many challenges at the public health level in Ghana. This capstone presents a narrative review of the existing literature to identify barriers to improving mental health care services and, particularly, to discuss their relevance to child and adolescent mental health in Ghana. Key barriers identified include: the low priority attached to mental health service delivery as a public health issue, scarcity of resources for mental health, inequities in access to mental health care and the lack of collaboration formal and informal health providers. Recommendations for overcoming these barriers centered on the need to increase political will, the need for greater advocacy and clear policy and legislation to reduce the unmet needs to children and adolescents in Ghana.

Keywords: mental health, children and adolescents, Ghana, barriers, mental health system

Dedication

In loving memory of my father, Dr. S. Twumasi-Afryie a man of faith, strength and integrity.

May 5, 1949- January 3, 2013

Thank you for your wise words, encouragement and most of all unconditional love. Your research and service to small-scale farmers all over Africa cultivated my passion for public health and drive to work for underserved individuals and communities. The many lessons you taught me have brought me thus far.

I love you.

Acknowledgements

My MPH degree and capstone would not have been made possible without the support of many people. I would particularly like to thank Dr. Kelley Lee, my senior supervisor, for her guidance and feedback during my MPH and Dr. Marina Morrow for kindly agreeing to be my second reader. I would like to thank my family and friends for their ongoing love, prayers, encouragement and support.

Table of Contents

Approval.....	ii
Abstract.....	iii
Dedication.....	iv
Acknowledgements.....	v

Introduction Error! Bookmark not defined.

Rationale.....	1
----------------	---

Background and Critical Review of the Literature..... 4

Country context.....	4
Current Mental Health System	5
<i>Scope of mental health services</i>	6
<i>The Role of Informal Health Care Providers</i>	7

Methods 9

Results 11

Low priority attached to mental health service delivery as a public health issue	11
Competing priorities of mental health needs.....	11
Top down decision making.....	12
Scarcity of resources.....	12
Mental Health Services	13
Collaboration between formal and informal systems of care.....	14
Inequities in access to mental health care.....	14
Stigma 15	
Addressing the barriers to improved child and adolescent mental health services	16
Alerting policy makers about the magnitude of child mental health problems	16
Policy and legislation affecting children	17
Advocacy.....	18
Collaboration between formal and informal systems of care.....	18

Discussion 19

Implications and recommendations 22

Conclusion 24

References 31

Appendix A. 38

Introduction

Child and adolescent mental health is defined by the World Health Organization (WHO) as “the capacity to achieve and maintain optimal psychological functioning and wellbeing. It is directly related to the level reached and competence achieved in psychological and social functioning” (World Health Organization, 2005 p. 7). Mental health is viewed as essential to subjective well-being, and to our ability to perceive, comprehend and interpret our surroundings, to adapt to them or change them if necessary, and to communicate with each other and have successful social interactions (Lehtinen et al., 2005, p. 46). Globally, neuropsychiatric disorders are a leading cause of health-related burden, accounting for 15–30% of the disability-adjusted life-years (DALYs) (Kieling et al., 2011). The burden of disability is highest in African countries many of which are classified as low and middle income countries (LMICs). Mental health is a serious public health issue and many LMICs struggle to address them within their health systems. In low-resource settings, there remains a lack of policies and limited mental health services to meet demand (Saraceno et al., 2007). Furthermore, in such settings, women, children and the elderly are more vulnerable to common mental disorders due to rapid social change, the risk of violence and social inequity which impede their rights to live healthy lives (Lund et al., 2011; Patel, Jenkins, & Lund, 2012).

Rationale

Child and adolescent mental health is central to global mental health—and to global health in general. Children and adolescents below the age of 18 constitute about a third of the world’s population, with about 90% living in LMICs (Kieling et al., 2011). Increasing recognition of the relevance of child and adolescent mental health globally, and in low-resource settings specifically, is deemed important for the achievement of, for example, the Millennium Development Goals which include improving maternal and child health, universal education, HIV/AIDS and eradicating poverty (Barry, Clarke, Jenkins, & Patel, 2013; Cortina et al., 2012; Sachs & McArthur, 2005). The negative impact of mental disorders in childhood and adolescence results in a variety of negative

outcomes, ranging from poor educational attainment to increased mortality rates which directly affect realisation of the MDGs (Kieling, Soledade Graeff-Martins, Hamoda, 2004). The public health significance of poor mental health in children and adolescents is associated with exposure to stigma, discrimination, heightened risk of premature death, functional impairment of mental disabilities(Costello, Foley, & Angold, 2006).

Addressing the burden of mental disorders presents enormous challenges at the clinical and public health levels, particularly in the context of limited resources. Due to the large deficits in mental healthcare, the Global Movement for Mental Health set out three key objectives: the scaling up of mental health services, protecting human rights, and promoting research in LMICs. Recommended strategies for the delivery of mental health care empathize the need for decentralization of health services, community-based mental health, and the integration of mental health within primary care (Saxena, Thornicroft, Knapp, & Whiteford, 2007; WHO, 2005). Furthermore, it has been proposed that governments establish national bodies to monitor the protection of the human rights of all citizens including those with mental health needs. Despite the widespread dissemination of evidence and recommendations for the adoption of a wide range of mental health interventions, there have been limited improvements globally to date.

This raises the key question of what barriers hinders progress? The definition of 'barriers' used in this capstone is similar to that used by Wells et al. (2002): 'factors that increase risks for [mental health] disorders, worsen their course or impact, or lead to inefficient use of health care or societal resources' (p. 658). Research in high-income settings have identified barriers to child mental health care to include lack of availability of providers, long waiting lists, lack of or inadequate insurance coverage, inability to pay for services, transportation problems, and inconvenient services. However, there is little research on barriers in low-income settings (Christian Kieling, Ana Soledade Graeff-Martins, Hesham Hamoda, 2004). The primary barriers to improving mental health services in LMICs, identified in a *Lancet* series on global mental health, are prevailing public-health priorities and its effect on funding for mental health services; challenges to implementation of mental health care in primary-care settings; lack of human resources; and the frequent scarcity of public health perspectives in mental health leadership due leadership positions dominated by people mostly trained in clinical management, public health training that does not include mental health (Saraceno et al., 2007). Stigmatization of patients and professionals, lack of public awareness about the causes of mental illness, low priority by

policy makers, and loss of mental health professionals through brain drain have been identified in other literature on LMICs (Esan et al., 2014;Kieling et al., 2011; WHO 2005).

Like many LMICs, services for the prevention and treatment of mental health in Ghana, where 40% of the population are children and youth, are scarce (D. M. Roberts, Asare, Mogan, Adjase, & Osei, 2013). The WHO estimates that 650,000 Ghanaians suffer from severe mental disorders, and a further 2.7 million suffer from mild to moderate mental health disorders (WHO 2007). The prevalence of mental health has not been fully studied in Ghana, although it is estimated that mental disorders represent 9% of the disease burden. However, the prevalence of child mental health disorders is not known. Given the above, mental health is an important public health issue in Ghana (Ofori-Atta, Read, & Lund, 2010a).

Ghana is in a unique position in West Africa to respond to the challenge of improving mental health. Though it is classified as a low-income country, it has one of the highest literacy rates in the region at 71 % literate. It is also a stable country with a diverse civil society (UNICEF, 2013). In this context, Ghana has come a long way in addressing child and adolescent health within a rights framework, ratifying the United Nations Charter on the Rights of the Child in 1990 which obligates governments to ensure children are protected and decisions are made in their best interests and adopting the Mental Health Act in 2012, devoting rights to people with ill mental health and protection of vulnerable groups (Ame & Mfoafo-M'Carthy, 2016; Mfoafo-M'Carthy & Sottie, 2015a). Despite this, there remains an enormous gap in the treatment and prevention of mental health. Research on mental health thus far has primarily focused on policy implementation and evaluation on how Ghana fairs in relation to other African countries, such as Uganda and South Africa. However, there remains a lack of research to understand the barriers impeding the promotion of mental health within the health care system in Ghana (Kleintjes, Lund, & Flisher, 2010).

Given the paucity of information on mental health in Ghana, the purpose of this capstone is to conduct a narrative analysis of the existing literature to identify the main barriers to improving mental health care and, particularly, to discuss their relevance to child and adolescent mental health. Identification of barriers to the improvement of child and adolescent mental health services may assist in formulating appropriate interventions. Moreover, if these barriers continue to exist, they could exacerbate problems of inequity and the health care system is less likely to respond to the needs of the population.

Background and Critical Review of the Literature

Country context

Ghana is defined as a lower-middle income country in West Africa, with an annual GDP growth rate of 4.8% in 2014 (World Bank, 2016). The national population was recorded at 26.3 million in 2015. With its capital city in Accra, the country is divided into 10 administrative regions and 138 decentralized districts. Ghana has experienced a rapid demographic transition over recent years. As shown in the population pyramids in Figure 1, Ghana has experienced declining birth rates, decreased mortality and improved life expectancy since 1970. In regards to specific trends, in 1970, the population of Ghana was 8.8 million; however, this figure nearly tripled by 2013, as the national population was recorded at 26.3 million (United States Census Bureau, 2013). This figure is expected to further increase with time, as the population for 2030 is projected to be 36.1 million (United States Census Bureau, 2013). Within these statistics, the median age of the population was 20.2 years. Furthermore, only 4.6% of the population was over the age of 65; however, this is projected to increase to 8.9% by 2050 (GSS, 2011). Thus, the population in Ghana is relatively young but is growing older with time. Much of this change in population dynamics can be attributed to substantial declines in child mortality. The life expectancy was 57 years for males and 64 years for females (World Bank, 2012). The literacy rate was 67.3 % (WHO, 2010). Around 21.4% of the population lives under the poverty line of \$1.90, down from 52.6% between 1991 and 2012 (Molini & Paci, 2015).

In regards to fertility, Ghana's fertility is ranked high compared to Global and West African averages (Population Reference Bureau, 2014). However, it is important to note that the total fertility rate (TFR) in Ghana has been steadily declining. To expand, in 1970, the TFR per female of childbearing age was 6.9 children born/woman; however, this figure dropped substantially to 4.1 children born/woman in 2015 (Population Reference Bureau, 2014). This is projected to further decline to 3.5 children born/woman by 2030. In regards to variations in fertility within the country, noticeable differences persist between urban-rural populations, as the fertility rate is 3.3 in urban centres compared to 5.5 in rural areas. In total, Ghana's northern region has the highest TFR at 6.2 children per woman (GSS, 2011).

Overall, the triangular population pyramid shown in 1970 is projected to shift towards the shape of a rectangle by 2030. This highlights that Ghana is moving away from high infant mortality and high fertility, to lower rates of fertility and higher rates of child survival (Hyder & Morrow, 2006). In this regard, Ghana's population is becoming older with time as the country begins to improve its capacity and ability to address high mortality rates and overall public health problems. This has had major implications for epidemiology. Whilst population dynamics are shifting, changes in disease pattern are beginning to emerge. More specifically, Ghana is shifting from high communicable to non-communicable disease prevalence (Institute for Health Metrics and Evaluation (IHME), 2012). In regards to non-communicable diseases, approximately 34.27% of the total disease burden and 42% of all deaths can be attributed to non-communicable diseases (WHO, 2014).

Current Mental Health System

Ghana operates a dual health care system - a conventional biomedical scientific system introduced during the colonial period and a traditional religious system (Ame & Mfoafo-M'Carthy, 2016). During the early colonial period, mentally ill patients were kept in prisons until the introduction of the Lunatic Asylum Ordinance of 1888, marking the first official patronage of Ghana's mental health services. A 'lunatic asylum' was built in Accra, and later transformed in 1904 to the Accra Psychiatric Hospital in line with international practice at the time (Ewusi-Mensah, 2001). The focus of the asylum was to keep individuals away from the public, while inmates endured prolonged physical restraint and tranquilizing drugs (Addai & Andrees, 2015; R. K. Ame, 2011). Following the creation of the first hospital in Accra, two other public psychiatric hospitals have been built (Barke, Nyarko, & Klecha, 2011).

The mental health system in Ghana is primarily funded by the government though healthcare is provided within the private and public sectors. The Ministry of Health controls all aspects of the health care system including the development of health policies and legislation, monitoring and evaluation and health care delivery (Roberts, Mogan, & Asare, 2014). The Mental Health Unit oversees mental health services including managing government psychiatric hospitals, advising on mental health policies and legislation, and monitoring and assessment of mental health services (Ofori-Atta, Read, & Lund, 2010b). Traditional and faith-based healers are also to under the responsibility of the Mental Health Unit although there is limited regulation of

their practice (Ofori-Atta et al., 2010b). The health expenditure is 4.5% of the country's gross national product (Canada, 7%) only 0.5% of the health budget is spent on mental health (USA, 6%), with 100% of this allocated to the three psychiatric hospitals (Jacob et al., 2007; Raja et al., 2012; Roberts et al., 2014). In addition to public funding, international development organizations fund the purchase of medications and mental health care. Despite these resources, the main financial burden falls directly on individuals and families through private services and traditional healers and faith-based systems (Roberts et al., 2013). The last revision of mental health rights was introduced in 1972 through enactment of the Mental Health Decree (Doku, Wusu-Takyi, & Awakame, 2012). In 2012, the Ghanaian Parliament enacted the Mental Health Act, a major milestone in addressing mental health as a public health issue (Ame & Mfoafo-M'Carthy, 2016). The mental health decree emphasized institutional care while the Mental Health Law was set to provide rights of people with ill mental health and vulnerable groups and promote support for people living with ill mental health (Mfoafo-M'Carthy & Sottie, 2015b).

Scope of mental health services

Since independence in 1957, the mental health care delivery system has not diverged far from its colonial legacy (Barke et al., 2011). The system is heavily dependent on curative care, with large gaps in the provision of service to the general population, but notably for children and adolescents (K. Ae-Ngibise et al., 2010). As mentioned above, there are three psychiatric hospitals in the entire country: two in Accra (Accra Psychiatric Hospital, Pantang Hospital) and one in Cape Coast (Ankaful Hospital). All three hospitals are located in the south of the country which are mostly urban areas not accessible to rural and distant communities. This has encouraged abandonment of patients whose families are not able to provide care and support in some cases at existing hospitals (Ewusi-Mensah, 2001; Mfoafo-M'Carthy & Sottie, 2015a).

The Accra Psychiatric Hospital is the only hospital with a designated children's ward. Despite this, reports suggest the range of patients within the ward was 14-40 years, with adult patients occupying this space since 1980 (Jimenez, 2012; Roberts et al., 2014). There are 123 mental health outpatient facilities available in the country, none of which serve children and adolescents (WHO-AMIS, 2011). As in many LMICs, the literature suggests Ghana faces an acute shortage of staff within the public health system as shown in Table 1 (Roberts et al., 2014).

Table 1: Human resources for mental health in Ghana and Canada		
	Ghana	Canada
Psychiatrists per 100 000 people	0.08	12
Psychiatric nurses per 100 000 people	5.19	44
Psychologists per 100 000 people	0.08	58

The Role of Informal Health Care Providers

Prior the creation of the asylum system, individuals with mental illness were treated by traditional forms of care, dating from pre-colonial times (Mfoafo-M’Carthy & Sottie, 2015a). In addition, Ghana has a deep-seated tradition of religious observers made up of Animists, Christians, and Muslims (Read, Adiibokah, & Nyame, 2009). Traditional healing practices are still widely used within African societies, even in the advent of advances in western style psychiatric health care (Ae-Ngibise, Doku, Asante, & Owusu-Agyei, 2015). The Ghanaian Ministry of Health estimates that 70-80% of the population uses traditional, non-biomedical forms of medicine as the first line of treatment for illnesses including mental health (WHO, 2007). The number of traditional healers outweighs professional mental health practitioners in Ghana. This informal sector comprises of an estimated 45,000 traditional healers and church facilities throughout the country (WHO, 2007). There is one traditional healer for every 200 people compared to the ratio for medical doctors is 1:2000 and 1: 1,470, 588 for psychiatrists (Ofori-Atta et al., 2010a; Tabi & Frimpong, 2003).

Faith-based facilities run by religious leaders such as pastors and imams operate ‘prayer camps’ which provide spiritual care for various physical, mental and emotional issues (Jimenez, 2012). Treatment practices by faith-based healers include fasting, prayer and the use of holy water (Edwards, 2014; Jimenez, 2012). A survey across 10 faith-based facilities in 2011 revealed that around 1200 people were treated for mental health issues, with 8% treating children or adolescents (M. Roberts et al., 2014). In addition to spiritual practices, 56% of practitioners administered medications and 22% used herbal remedies. Furthermore, 57.5 % used restraints across the vast majority of these facilities (Roberts et al., 2014). Traditional healers, called ‘okomfoo’ in the Ashanti language of Twi, administer local herbs for treatment of diseases and ailments, and sacrifices to gods at shrines. Akin to faith-based healers, the majority of people who

seek help from okomfoo were women (39%), while 8% were child or adolescents (Roberts et al., 2014).

The widespread use of traditional and faith-based healers have been credited for their ability to provide psychosocial and social support and the accessibility and affordability of their services (Read et al., 2009). This is further underscored by dominant understandings of mental illness. The beliefs and practices of traditional and faith healers are intimately connected to local communities (Ae-Ngibise et al., 2010). Consensus among the general public tends to recognize mental illness as a 'spiritual illness' and attributed to 'juju', 'supernatural powers' and 'evil spirits' (Jimenez, 2012). Avoidance of mental hospitals is a direct result of the social and cultural repercussions of mental illness diagnosis and treatment in the country, for example there is a popular saying, among the Akans ethnic group of Ghana, "odamfo se ne dam ko a kakra wo de be hunahuna nkwadaa dea ewo ho" which means that once a person is diagnosed to have mental illness, no amount of treatment can totally cure such a person" (Addai & Andrees, 2015, p. 171).

Methods

To analyse the barriers to strengthening mental health care in Ghana, literature was identified and reviewed to address the following primary question: ‘Despite government support and legislation, what are the barriers explaining the slow pace of improvement to mental health care delivery in Ghana?’ In addition to reviewing Ghana, this capstone reviews literature to understand what approaches and initiatives have been used in other countries to overcome these barriers that may be applicable to the Ghanaian context.

A narrative review is used given the need to cover a wide range of issues (Educational Research Review, 2009). The Cochrane Research Methods Review Group noted that meta-analyses and systematic reviews may not provide clear guidance for policy and practice, nor address the translation of research evidence into local practice. A systematic review, in particular, is used to determine breadth and methodological quality of literature. However, this capstone aims to discuss the current context of the mental health system. A narrative review seeks to comprehensively use existing literature to tell a purposeful story, by focusing on a subset of information, and using a wide variety of sources that goes beyond the more rigid systematic review (Uman, 2011).

The WHO assessment instrument for mental health systems (WHO-AIMS) is a tool developed to collect information on available resources within a mental health system (WHO 2011). The six domains are (i) policy and legislative frameworks; (ii) mental health services; (iii) mental health in primary care; (iv) human resources; (v) public education and links with other sectors; and (vi) monitoring and research. The WHO-AMIS was designed to address the needs of mental health in LMICs specifically and covers a wide range of indicators. Additionally, it was utilized in this capstone as it provides a baseline for monitoring changes to the mental health system therefore barriers identified within this capstone relevant to the 6 domains as part of the inclusion criteria. Articles were identified gathered using the six domains as a reference, the results were then categorized into themes from the data that were relevant to the six domains of the WHO-AIMS assessment tool.

Data was drawn from two primary sources: (i) peer-reviewed literature; and (ii) grey literature (e.g. country reports, publications, WHO reports. Peer-reviewed literature was identified

through electronic searches of databases such as the Web of Science, Medline OVID, PsychInfo, Global Health, PubMed, and JSTOR & CINAHL (EBSCO). Google Scholar was used to locate additional scholarly materials given the limited literature relevant articles to this topic. Grey literature was similarly identified using a general internet search using Google. The key search terms used for both search strategies employed the following keywords (in combination or alone): mental health, disability, child and adolescents, barriers, Ghana, Africa, human rights, West Africa, mental health system, psychiatry, mental health policy, structural factors. To ensure a comprehensive identification of all relevant studies, both search strategies involved free-text searching as well as additional terms (including appropriate MeSH terms). Inclusion criteria were: full text available in English language, articles with a full abstract, and articles relevant to the research question, information relevant to the WHO-AMI 6 domains. Exclusion criteria were: non-full text articles, articles without an abstract, lack of relevance to the research question. After screening for relevance to the research topic, articles were identified that met the inclusion criteria. Due to the anticipated diversity of article types, I focused on identifying key themes, and then collated these findings in relation to barriers to mental health care services identified in the literature pertaining to LMICs.

Results

Low priority attached to mental health service delivery as a public health issue

A primary barrier to mental health care in Ghana is low priority given to the mental health overall (Awenva et al., 2010; Bird et al., 2011; Kleintjes et al., 2010). Stakeholders from both health and non-health sectors in Ghana have expressed that there was low priority among decisions makers at the national and regional levels, which were responsible for implementing services and programme thus hindering progress on mental health. A review of mental health policy implementation concluded that ‘there is a lot of lip service in terms of commitment to implement the mental health strategies and plans’ (Awenva et al., 2010, p. 191). Bird et al., (2011) identified low perceived legitimacy of the problem and its impact as a factor affecting the low priority given to mental health in Ghana. Firstly, this was due to an underappreciation of the prevalence of mental illness. Routine data ranked mental illness 12th for outpatient consultations in the country however, the prevalence of mental illness is not clearly identified in health information systems (Bird et al., 2011; Faydi et al., 2011; Read & Doku, 2012). In addition, the invisibility of individuals and their families dealing with ill mental health has been cited as another factor for the lack of understanding of the impact of ill mental health. This is further compounded by stigma and discrimination against people ill mental health within the general public, thus access to mental health care is severely limited.

Competing priorities of mental health needs

In addition to low priority given to this public health issue, competing health and development priorities in the country also hinder progressive action on mental health. In Ghana, national development priorities have largely not included mental health. A factor for this is due to healthcare policy reform. Following the Structural Adjustment Programs (SAPs) introduced in the latter half of the 1980s, Ghana’s healthcare system reflected the neoliberal ideologies favouring privatization and deregulation of many public services (IFPRI, 2013). These policies severely impacted the health system. Healthcare budgets, among other public expenditures, were severely cut in favour of reducing external debt and generating macro-economic growth. SAPs were not only deleterious to the national health system, which was already severely underfunded,

understaffed, and technologically unequipped to manage the rising disease burden, but had crippling effects on the health of Ghanaians who lived below the poverty line and simply could not endure the additional financial burdens created by a 'cash and carry' health financing model (IFPRI, 2013; WHO, 2009). Amid the negative impact of the twin challenges of economic turmoil and poverty on public health, communicable diseases received higher priority in Ghana, in large part, due to the disease-focused vertical solutions supported by donor agencies. Additionally, high priority has been given to maternal and infant mortality rates for example because data is easier to collect. Furthermore, there is no information on the socio-economic impacts of child and adolescent mental health thus policy makers are largely unaware of the benefits of tackling poor mental health. As a result, mental health care has not been given priority in Ghana resulting in its exclusion from national development priorities and policies.

Top down decision making

At the national level, political apathy towards mental health, combined with widespread stigma, have been shown to hamper the progress of mental health particularly in the implementation of mental health policy (Flisher et al., 2007). In the creation of a general mental health policy, no consultation was conducted with key stakeholders such as the departments responsible for human resources, child health, ministries of finance or social welfare, along with users of mental health services (Awenva et al., 2010). Faydi et al., 2011, posit that too often the drafting of policy was restricted to a group of mental health specialists 'who concentrate their efforts in putting together a 'technically sound' policy document, entirely based on their clinical and/or research experience" (p.9). This top-down approach taken to policy implementation demonstrated a failure to disseminate the provision of mental health policy at the regional and district levels

Scarcity of resources

Another theme in the literature is the limited public resources for mental health services and treatment, these include community, financial and human resources (Roberts et al., 2014). Funding for child and adolescent mental health services is hard to identify as it is most often paid out-of-pocket or privately in African countries (Raja, S., Wood, S. K., de Menil, V., & Mannarath, 2010). It is estimated that 71.4% of costs for mental health care are paid out-of-pocket (WHO,

2005). Views expressed by some health professionals disclosed that mental illness is seen as a lost cause to some, due to the perception that care is not cost-effective (Raja et al., 2010). As 100% of the budget is given to psychiatric hospitals, the care provided to individuals is hampered given an over-reliance on psychiatric hospitals, leading to custodial rather than rehabilitative care, and an insufficient choice in treatment (Raja, S., Wood, S. K., de Menil, V., & Mannarath, 2010). Additionally a mismatch between mental health resources and the realities of mental health care in Ghana are clear (Knapp et al., 2006). The lack of mental health human resources in the identification, management, and referral of child and adolescent health are barriers to service provision across the health sectors, social services and in the educational sectors (Kleintjes et al., 2010).

Mental Health Services

The curative health framework of the formal Ghanaian mental health care system provides a series of challenges to the improvement of mental health services. A curative paradigm is based on the assumption of having adequate numbers of qualified health personnel, medication, and infrastructure. The mental health care system in Ghana, however, lags behind on all these fronts (Addai & Andrees, 2015). The large gaps in treatment point to inequity within the mental health care system. As mentioned, institutional care remains the norm and this limits access to many people in need due to the location of hospitals, cost of care, and stigma attached to mental health (Ofori-Atta et al., 2010a). The incongruity between health resources and the realities in the healthcare system suggests that the curative strategy to mental health is “destined to be a mirage” (Addai & Andrees, 2015, p. 169).

Community-based rehabilitation in Ghana is limited to physical disability and people with mental health needs are not acknowledged (Doku et al., 2012). Though people with mental illness are included under the Persons with Disability Act, mental health is not addressed within the disability framework of the country. There are 10 consumer associations/NGOs in Ghana, such as the Mental Health Society of Ghana (MEHSOG), The Ghana Mental Health Association, BasicNeeds, World Vision, The Epilepsy Society, Ghana Organization against Fetal Alcohol Syndrome and Psycho- mental Health International. Many of these organizations have been involved in the formulation or implementation of mental health policies, plans, or legislation at a

certain point. However, only less than 10% of the organizations worked in partnership with governmental mental health services (WHO, 2011).

Collaboration between formal and informal systems of care

The lack of collaboration between traditional/faith-based healers and conventional psychiatric services is another barrier to improving mental health. The Mental Health Act recognizes and seeks to regulate traditional healers and their practices however, collaboration between formal mental health providers and informal care service providers is lacking (Ae-Ngibise et al., 2010). Several factors have been identified on both sides for hindering collaboration. On one hand, conventional health care providers questioned the safety and efficiency of traditional and faith based healing practices particularly for more serious mental disorders. Some practitioners emphasized that very little clinical evidence exists concerning the quality of healing methods employed by traditional and faith-based healers and concerns regarding human rights impacts of traditional healing practices. It was expressed that collaborating with traditional and faith healers could be seen as 'condoning such practices' and 'encouraging abuse (Ae-Ngibise et al., 2010, p. 563). On the other hand, traditional and faith-based healers expressed skepticism around the effectiveness of conventional psychiatric treatments. Traditional healers have expressed lack of collaboration due differing to views of health and disease between them and medical practitioners (Ae-Ngibise et al., 2010). Additionally, the lack of collaboration stems of a lack of solidarity between conventional and traditional healers. For example, faith-based healers expressed preference for referring clients to another healer as opposed to conventional practitioners hindering collaboration and open dialogue between the two sectors.

Inequities in access to mental health care

Access to treatment and medications is a large burden as much of the population lives in poverty. Additionally, mental disorders are prevalent among populations that have the least access to them. In an attempt to reverse inequities in access and utilization of health services, the Ghanaian government in 2003, established the National Health Insurance Scheme (NHIS), and formally mobilized it in 2005 (Wahab & Assensoh, 2008). This national insurance plan

afforded all Ghanaians access to all government hospitals, health posts and essential medicines at low, yearly premiums. Services were to be provided at no cost for the extremely poor, elderly above 70 years old, pregnant women and children (Agyepong et al., 2014; Jehu-Appiah et al., 2011; Wahab & Assensoh, 2008). Enrollment in the health insurance scheme however was unequal and failed to reach the poor and vulnerable. Only 2% of the extremely poor are covered compared to 40% of the richest quintile (Gajate-Garrido & Owusua, 2013; Jehu-Appiah et al., 2011). Considering 29% of the population lives in extreme poverty, it has been suggested that the NHIS may be exacerbating the very inequities it intended to mitigate. Furthermore, the National Health Insurance Scheme (NHIS) does not cover psychiatric services as the treatment for mental health is to be provided by government psychiatric hospitals cost-free (Jimenez, 2012). Ghana relies completely on donor funding for psychiatric medications and when medications are unavailable, patients and their families are required to purchase them out of pocket causing barriers in access to treatment. Dr. Akwasi Osei, chief psychiatrist of the Ghana Health Service and director of Accra Psychiatric Hospital, stated that the “lack of resources to buy drugs is states sponsored human rights abuse”(Jimenez, 2012, p. 29).

Stigma

The literature identifies stigma and discrimination as overarching problems and cross-cutting issues affecting individual behavior and societal responses to improving mental health outcomes in Ghana (Barke et al., 2011; Ofori-Atta et al., 2010a). Across all countries, stigma towards people with mental illness contributes to discrimination and violation of human rights regardless of age. Stigma has been identified as a significant barrier in 68.1% of countries globally (WHO,2005). Nationally, misinformation and stigma against mental illness is prevalent, influencing willingness to disclose and seek help, quality of health care received, and access to family, community, and school support (Ame, Apt, & Agbényiga, 2012; Kleintjes et al., 2010). Parents of children and adolescents also bear the brunt of this burden, prompting some parents to deny their child has a mental illness and instead attribute their condition to a ‘bad omen’ (Kleintjes et al., 2010).

At the policy level, stigma from policy makers and decision makers has also been cited for affecting the lack of policy development and investment in mental health (Kleintjes et al., 2010).

Stigma is seen to have a direct impact on the lack of allocation of funds towards the mental health system. As a senior psychiatric expressed ‘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 cannot contribute to society’(Awenva et al., 2010, p. 187). In the same way, stigma not only affected individuals with mental illness and their families, but also those who work in the mental health field, and policy makers who are advocating for improved mental health in the field.

Addressing the barriers to improved child and adolescent mental health services

Identifying the barriers to improving mental health care is the first step in overcoming them and improving the use of scarce resources. The issue is how to firstly bring awareness to decision makers of the magnitude of child and adolescent mental health needs in the country. Secondly, there is a need for the development of a child and adolescent policy and implementation from the national to district level. Thirdly, there is a need for accessible, affordable services and appropriate services for children and adolescents. There are few peer-reviewed articles and published reports that succinctly describe successful strategies. The opportunities to overcome the barriers to improving mental health care described below have been synthesized from evidence of success and recommendation in the articles reviewed.

Alerting policy makers about the magnitude of child mental health problems

The low priority given to mental health in Ghana has been linked to the lack of information and a clear understanding of the mental health needs in the country from policy to community level. Evidence-based research on mental health is largely carried out in high-income settings. It is therefore harder to generalize this evidence from country to country because mental health systems, sociodemographic structures, cultural contexts vary. An example of a successful attempt to bolster political will is in Sri Lanka, where data was collected to demonstrate the presence of treatable child mental illness in the community. This data was then used to convince health planners to include child mental health services in the agenda of primary health care by way of multidisciplinary workshops consisting of professionals from the health, social and

education sectors. A national policy for child health and a core group to implement and monitor service development was created (Rahman, Mubbashar, Harrington, & Gater, 2000). This program was well received by policy makers in Sri Lanka and mental health became a part of child health services in the country.

Policy and legislation affecting children

A national child and adolescent mental health policy can play a vital role in bolstering action on mental health as illustrated in South Africa and Brazil (Robertson, 2004). Following the development and adoption of national policy guidelines for child and adolescent mental health, a national meeting on mental health was convened to address child mental health problems in South Africa (Department of Health Republic of South Africa, 2013). The child and adolescent mental health policy created was based on a needs assessment and extensive consultation with child and adolescent experts (Omigbodun, 2008). The mental health policy guidelines in South Africa provide for the development of age-specific services for mental health disorders, substance abuse, and prevention programs. Additionally, it recommends that funding for support for appropriate child and adolescent mental health research be provided by the state. The policy has also been reviewed to be aligned with health promotion strategies that are embedded into the country's general child and youth policy guidelines. The key strategies of their child and adolescent policy is the provision of a safe and supportive environment, skill building, counselling, and access to appropriate health services (Republic of South Africa, 2015). Faydi et al., (2011) calculated the human resources and costs required for the scale up of child and adolescent health services to cost \$21.50 and \$5.99 per child.

In Brazil, a mental health policy for children and adolescents was developed by highlighting the importance of intersectoral collaborative system among the health, child welfare and justice sectors. The unique feature of this system was the creation of the Guardianship Council, mandated by the Brazilian Child and Adolescent Rights Act to protect the rights of Brazilian children and adolescents and (Rahman et al., 2000). The Council acts to ensure that children who are at risk received care and address issues such as child abuse, inadequate health care and legal issues (Paula, Lauridsen-Ribeiro, Wissow, Bordin, & Evans-Lacko, 2012). Though the council does not provide services, it acts as a mediator between the community and intersectoral system to maintain the rights of children and adolescents (Paula et al., 2012).

Advocacy

Improved national advocacy, through a coordinated advocacy movement involving user group and NGOs, have been shown to bolster action on mental health. In Uganda strong mental health leadership within the Ministry of Health was identified as a driving factor for mental health policy and service provisions. Agents of change can be identified to propel this public health issue (Petersen, Swartz, Bhana, & Flisher, 2010). Advocacy has been shown to drive the provision of health issues in Ghana for example breast cancer in Ghana (Reichenbach, 2002). Political attention to breast cancer was spearheaded by women's groups in the country with the support of the first lady and created awareness programs and funding for mammography equipment. By promoting grassroots level action, the Ministry of Health became more involved at the district and community level, providing screening for women in rural areas in the country (Reichenbach, 2002).

Collaboration between formal and informal systems of care

According to Robertson et al (2004), systems of care are more likely to be successful where there is active coordination, collaboration, integration and mutual support between the various state sectors, the private sector and the informal sector. In Nigeria, a partnership between a faith-based organization and child mental health professionals in hospitals demonstrate that both sides could provide mental health to young offenders who were abandoned. Faith-based healers attend to the spiritual needs of the children while mental health professionals utilized a biomedical approach to the children diagnosed with mental illness (Juengsiragulwit, 2015).

Discussion

Mental health care in Ghana are lacking due to inadequate resources and continued reliance on institutional care. The barriers identified for slowing the progress of mental health care in Ghana are the low priority given to mental health, competing priorities, poor allocation of funding and resources, and the focus on the curative biomedical approach and stigma, which was is an overarching barrier to mental health care at the systems level and within the general public. The aim of this review was to draw on the literature to understand the barriers to improving mental health care in Ghana. The findings from this review, firstly posit that the current mental health situation in Ghana is similar to what it was 30 to 40 years ago. There are also a number of longstanding problems and structural barriers in the implementation of mental health policies and service delivery such as lack of funding, and stigma. Part of the problem is also that the evidence based information remains limited and much of it is based on expert opinions. There is very limited data over assessment or measurements of interventions.

Politics influences the provision of care and accessibility of services and the lack of priority given to mental health greatly affects health care delivery. The results reveal that the low priority given to implementing mental health care meaningfully, beyond the adoption of national legislation, is a fundamental barrier. The lack of priority, in turn, creates a self-perpetuating cycle. Mental health is given low priority, while there is a lack of data collected on the issues to persuade policymakers. This, in turn, leads to a lack of understanding and perception of mental health needs, and therefore policies are not implemented or upheld. The result is insufficient human resources and services for mental health. Political will, defined as “the inclination, shaped by convictions or incentives, for policymakers to take action and to make or block change”, directly affects mental health care in Ghana (Saraceno et al., 2007, p. 1171). The results of the literature also indicate that the availability of mental health data, and the perception that mental health indicators are not tangible and convincing, put mental health as public health issue on the back burner. This barrier has been identified by mental health experts and leaders in other LMICs (Saraceno et al., 2007). A need to develop an understanding of the type of information required by decision makers (e.g. mortality data, data on socio-economic impact) to be able to collect and package information in a way that is useful to decision makers is required to move forward. Mental health legislation still needs to build in provisions for the protection of the rights of children and adolescents as child and adolescent mental health is poorly represented in national mental health

policies (Awenva et al., 2010). The country has the capacity to include child and adolescent within its national mental health policies and plans however clarity on policy directions which can provide a basis to raise the issues of child and adolescent mental health within the health and other sectors is needed (Lund et al., 2010). Mental health policies will not solve all the issues outright however they will provide a framework to overcome the barriers associated with mental health provision. This points to the need for advocacy and highlights the role of mental health professionals, NGO's and research to put mental health on the political agenda (Gureje & Alem, 2000)

Mental health services in Ghana falls short of the suggested principles of the organization of services according to the WHO namely, accessibility, comprehensiveness, coordination, continuity of care, coordination of care, effectiveness, equity and respect for human rights (WHO 2003). The WHO recommends an optimal mix of mental health service model where the majority of people with ill mental health are treated with primary health care and the informal health sector. Those in need of specialized care and psychiatric care given the appropriate and everyone has access to the appropriate level of care(Ofori-Atta et al., 2010a; WHO 2003).

The results also reveal an important aspect that is largely overlooked, namely that cultural beliefs and practices are key issues in child mental health service development in Ghana. Not only are there a greater numbers of faith-based and traditional healers compared with professional mental health practitioners but more people in the general public seek help and care from the informal health sector. The formal health sector is yet to embrace the informal community. The Mental Health Bill stipulates that practices of traditional and faith-based healers be regulated; however, this is yet to be implemented in the country. Until mental health services are made accessible and available, help seeking behaviors will favor the informal community (Ofori-Atta et al., 2010a; Omigbodun, 2008). The informal sector, however, is not necessarily a barrier to mental health care in the country, but can be an opportunity to ensure those with mental illness, who come in contact with these care providers, are referred to the most appropriate services based on their needs.

There were limitations of the literature analyzed in this capstone. Limited data on child and adolescent mental health hinders better understanding of mental health needs, limits policy, interventions, and resources needed to address mental health. The data on mental health research in Ghana is firstly silent on the plight of child and adolescents with ill mental health. This

includes a lack of epidemiological data on the prevalence of child mental health, how children with ill mental health are being diagnosed and also the risk and protective factors of mental health in country. Secondly, the data also does not shed light on the child mental health disorders that relevant to Ghanaian culture. Thirdly, there was a lack of qualitative studies that aim to understand the local realities and lived experiences of children and their caretakers dealing with ill mental health. Fourthly, much of the qualitative data focused on research from expert opinions, policy makers and high level mental health practitioners in Ghana. While using key informants to obtain information from those thought to be most informed about mental health in Ghana is important, this does create the potential of lack of uniformity and reliability of data(World Health Organization, 2005).

Implications and recommendations

The results of literature review on barriers to the improvement to mental health demonstrate that, across the mental health system, there is a lack of priority given to mental health issues. The major difficulty has not usually been policy but its implementation. As mental illness has an early age of onset, it is imperative that mental health care in Ghana is provided to the young to off-put the onset of ill mental health in the future.

A top priority for mental health in Ghana is to increase research in this area. The literature is not only silent on mental health much more so for child and adolescent mental health. Key research areas should look into the prevalence of child and adolescent disorders, evaluate community attitudes and identify gaps in knowledge utilizing culturally informed methods. A cost-effective option for mental health research would be to share resources among countries to conduct epidemiologic surveys and these regional results could be more generalizable to national data (Omigbodun, 2008).

Policy and legislative frameworks can be powerful instruments to drive child and adolescent mental health care in LMICs including Ghana. Ghana was the first country to sign the UNCRC and thus is under obligation to ensure that children receive protection and all decisions are made in the best interests of the child. Appropriate advocacy and the collection of data and evidence on the prevalence and experience of children and their family's needs to be made available to enable greater legislative measures towards the implementation of positive mental health. Drawing on lessons from South Africa, the development and adoption of national policy guidelines for child and adolescents mental health would allow for the development of practical, acceptable and affordable packages that can be implemented(Omigbodun, 2008). The needs of children and adolescents span health, education, and welfare sectors. Therefore, it is essential for the child and adolescent mental health care are to be integrated into these sectors as they each play a role in the health and well-being of children. Developing common frameworks and interdisciplinary training would lead to a shared understanding of ways to improve mental health.

The scarcity of formally trained mental health professionals in many LMICs, including Ghana, suggests a greater need of services from the non-professional community members. The use of both formal and informal resources, already available in the country, can be used to

improve mental health care for example, Kieling et al. (2011) call for the integration of child mental health care into other pediatric and primary care settings to bolster mental health and physical outcomes for children and adolescents.

Given the shortage of professional mental health in Ghana, task shifting, using trained community based-workers, is method proposed to make better use of the limited number of trained mental health professionals (Kakuma et al., 2011; Petersen et al., 2010; Saraceno et al., 2007). Questions about which tasks should be shifted, the management of task-shifting for example, will need to be assessed moving forward. Task shifting is not a solution for the paucity of mental health specialists. However, it is been a successful approach in LMICs within a stepped care approach (Petersen et al., 2010). In addition to task shifting, traditional and faith-based healers also possess qualities that can be used to support mental health care in the country. They are embedded in the local fabric of communities, are accessible and their consultations are stigma free (Roberts, 2001). As such, they are consulted in times of health and illness rather than alienating them from the provision of mental health, they can gatekeepers and advocates for positive mental health.

Conclusion

This capstone reveals that mental health services in Ghana remains largely unimplemented. Barriers to the improvements of mental health in the country included the low priority of mental health, inadequate funding and resource allocation, lack of human resources and the dominance of a curative paradigm for mental health, all these factors are underscored by stigma towards mental health in the country. The burden which families and children carry as a result of the human and economic loss and the hidden burden on children who suffer as a result of stigma and neglect continue go unnoticed. The provision of child and adolescent mental health in Ghana requires a specific strategy to maximize the potential of limited resources. Policy development and implementation is essential to enhance key aspects of the mental health system. In order to establish viable child and adolescent mental health care services in Ghana, the burden of the disease needs to be clearly defined and there is a need for advocacy at the grassroots level to address this pertinent public issue that remains invisible to policymakers, and the general public.

References

- Addai, I., & Andrees, A. R. (2015). PREVALENCE AND PREDICTORS OF SYMPTOMS OF MENTAL DISORDERS IN GHANA. *Current Politics & Economics of Africa*, 8(2), 165–199. Retrieved from <http://proxy.lib.sfu.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=poh&AN=112197835&site=ehost-live>
- Ae-Ngibise, K. A., Doku, V. C. K., Asante, K. P., & Owusu-Agyei, S. (2015). The experience of caregivers of people living with serious mental disorders: a study from rural Ghana. *Global Health Action*, 8(0).
- Ae-Ngibise, K., Cooper, S., Adiibokah, E., Akpalu, B., Lund, C., & Doku, V. (2010). "Whether you like it or not people with mental problems are going to go to them": A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. *International Review of Psychiatry*, 22(6), 558–567. <http://doi.org/10.3109/09540261.2010.536149>
- Agyepong, I. A., Aryeetey, G. C., Nonvignon, J., Asenso-Boadi, F., Dzikunu, H., Antwi, E., ... Arhinful, D. K. (2014). Advancing the application of systems thinking in health: provider payment and service supply behaviour and incentives in the Ghana National Health Insurance Scheme - a systems approach. *Health Research Policy and Systems / BioMed Central*, 12(1), 35. <http://doi.org/10.1186/1478-4505-12-35>
- Ame, R. K. (2011). The Rights of Children in Conflict with the Law in Ghana. *The International Journal of Children's Rights*, 19(2), 271–293. <http://doi.org/10.1163/157181810X528003>
- Ame, R. K., Apt, N. A., & Agbényiga, D. L. (2012). *Children's Rights in Ghana*. Lexington Books. Retrieved from <http://lib.myilibrary.com.proxy.lib.sfu.ca/Open.aspx?id=391200>
- Ame, R., & Mfoafo-M'carthy, M. (2016). Mental Health Law in Ghana: The Rights of Children with Mental Disorders. *Social Development Issues*, 38(1).
- Awenva, a D., Read, U. M., Ofori-Attah, a L., Doku, V. C. K., Akpalu, B., Osei, a O., & Flisher, a J. (2010). From mental health policy development in Ghana to implementation: what are the barriers? *African Journal of Psychiatry*, 13(3), 184–91. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/20957317>

- Barke, A., Nyarko, S., & Klecha, D. (2011). The stigma of mental illness in Southern Ghana: attitudes of the urban population and patients' views. *Soc Psychiatry Psychiatr Epidemiol*, *46*, 1191–1202. <http://doi.org/10.1007/s00127-010-0290-3>
- Barry, M. M., Clarke, A. M., Jenkins, R., & Patel, V. (2013). A systematic review of the effectiveness of mental health promotion interventions for young people in low and middle income countries. *BMC Public Health*, *13*. <http://doi.org/10.1186/1471-2458-13-835>
- Bird, P., Omar, M., Doku, V., Lund, C., Nsereko, J. R., Mwanza, J., & MHaPP Research Programme Consortium, the Mh. R. P. (2011). Increasing the priority of mental health in Africa: findings from qualitative research in Ghana, South Africa, Uganda and Zambia. *Health Policy and Planning*, *26*(5), 357–65. <http://doi.org/10.1093/heapol/czq078>
- Christian Kieling, Ana Soledade Graeff-Martins, Hesham Hamoda, and L. A. R. (2004). Child and Adolescent Mental Health, 39(154).
- Cortina, M. A., Sodha, A., Fazel, M., Ramchandani, P. G., M, R., S, G.-M., ... EJ, C. (2012). Prevalence of Child Mental Health Problems in Sub-Saharan Africa. *Archives of Pediatrics & Adolescent Medicine*, *166*(3), 276. <http://doi.org/10.1001/archpediatrics.2011.592>
- Costello, E. J., Foley, D. L., & Angold, A. (2006). 10-year research update review: the epidemiology of child and adolescent psychiatric disorders: II. Developmental epidemiology. *Journal of the American Academy of Child and Adolescent Psychiatry*, *45*(1), 8–25. <http://doi.org/10.1097/01.chi.0000184929.41423.c0>
- Department of Health Republic of South Africa. (2013). *NATIONAL MENTAL HEALTH POLICY FRAMEWORK AND STRATEGIC PLAN 2013-2020*. Republic of South Africa.
- Doku, V. C. K., Wusu-Takyi, A., & Awakame, J. (2012). Implementing the Mental Health Act in Ghana: any challenges ahead? *Ghana Medical Journal*, *46*(4), 241–50. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3645169&tool=pmcentrez&rendertype=abstract> \ngoogle scholar
- Edwards, J. (2014). Ghana's mental health patients confined to prayer camps. *The Lancet*. [http://doi.org/10.1016/S0140-6736\(13\)62717-8](http://doi.org/10.1016/S0140-6736(13)62717-8)
- Esan, O., Abdumalik, J., Eaton, J., Kola, L., Fadahunsi, W., & Gureje, O. (2014). Global Mental Health Reforms: Mental Health Care in Anglophone West Africa. *Psychiatric Services*, *65*(9), 1084–1087. <http://doi.org/10.1176/appi.ps.201300300>
- Ewusi-Mensah, I. (2001). Post colonial psychiatric care in Ghana. *Psychiatric Bulletin*,

25(6), 228–229. <http://doi.org/10.1192/pb.25.6.228>

Faydi, E., Funk, M., Kleintjes, S., Ofori-Atta, A., Ssbunnya, J., Mwanza, J., ... Kelly, B. (2011). An assessment of mental health policy in Ghana, South Africa, Uganda and Zambia. *Health Research Policy and Systems*, 9(1), 17. <http://doi.org/10.1186/1478-4505-9-17>

Flisher, A. J. ., Lund, C., Funk, M., Banda, M., Bhana, A., Doku, V., ... Green, A. (2007). Mental Health Policy Development and Implementation in Four African Countries. *Journal of Health Psychology*, 12(3), 505–516. <http://doi.org/10.1177/1359105307076237>

Gajate-Garrido, G., & Owusua, R. (2013). The National Health Insurance Scheme in Ghana Implementation Challenges and Proposed Solutions.

Gureje, O., & Alem, A. (2000). *Mental health policy development in Africa*.

Institute for Health Metrics and Evaluation (IHME). (2012). 2010 global burden of disease study. GBD Profile Ghana. Retrieved from <http://www.healthdata.org/results/country-profiles>

Jacob, K. S., Sharan, P., Mirza, I., Garrido-Cumbrera, M., Seedat, S., Mari, J. J., ... Saxena, S. (2007). Mental health systems in countries: where are we now? *Www.thelancet.com*, 370. <http://doi.org/10.1016/S0140>

Jehu-Appiah, C., Aryeetey, G., Spaan, E., de Hoop, T., Agyepong, I., & Baltussen, R. (2011). Equity aspects of the National Health Insurance Scheme in Ghana: Who is enrolling, who is not and why? *Social Science & Medicine (1982)*, 72(2), 157–65. <http://doi.org/10.1016/j.socscimed.2010.10.025>

Jimenez, R. (2012). “Like a Death Sentence” Abuses against Persons with Mental Disabilities in Ghana. Retrieved from <http://www.hrw.org>

Juengsiragulwit, D. (2015). Opportunities and obstacles in child and adolescent mental health services in low-and middle-income countries: a review of the literature. *WHO South-East Asia Journal of Public Health*, 4(2).

Kakuma, R., Minas, H., van Ginneken, N., Dal Poz, M. R., Desiraju, K., Morris, J. E., ... Scheffler, R. M. (2011). Human resources for mental health care: current situation and strategies for action. *The Lancet*, 378(9803), 1654–1663. [http://doi.org/10.1016/S0140-6736\(11\)61093-3](http://doi.org/10.1016/S0140-6736(11)61093-3)

Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., ... Rahman, A. (2011). Child and adolescent mental health worldwide: evidence for action. *The Lancet*, 378(9801), 1515–1525. [http://doi.org/10.1016/S0140-6736\(11\)60827-1](http://doi.org/10.1016/S0140-6736(11)60827-1)

- Kleintjes, S., Lund, C., & Flisher, a J. (2010). A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia. *African Journal of Psychiatry*, 13(2), 132–139. <http://doi.org/10.4314/ajpsy.v13i2.54360>
- Knapp, M., Funk, M., Curran, C., Prince, M., Grigg, M., & McDaid, D. (2006). Economic barriers to better mental health practice and policy. *Health Policy and Planning*, 21(3), 157–170. <http://doi.org/10.1093/heapol/czl003>
- Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J. A., ... Patel, V. (2010). Poverty and common mental disorders in low and middle income countries: A systematic review. *Social Science & Medicine*, 71(3), 517–528. <http://doi.org/10.1016/j.socscimed.2010.04.027>
- Lund, C., De Silva, M., Plagerson, S., Cooper, S., Chisholm, D., Das, J., ... Patel, V. (2011). Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. *The Lancet*, 378(9801), 1502–1514. [http://doi.org/10.1016/S0140-6736\(11\)60754-X](http://doi.org/10.1016/S0140-6736(11)60754-X)
- Mfoafo-M'Carthy, M., & Sottie, C. A. (2015a). Current practices in community treatment of the mentally ill in Ontario, Canada: learning opportunities for improving Ghana's mental health system. *International Journal of Culture and Mental Health*, 1–11. <http://doi.org/10.1080/17542863.2015.1055333>
- Mfoafo-M'Carthy, M., & Sottie, C. A. (2015b). Current practices in community treatment of the mentally ill in Ontario, Canada: learning opportunities for improving Ghana's mental health system. *International Journal of Culture and Mental Health*, 8(4), 359–369. <http://doi.org/10.1080/17542863.2015.1055333>
- Molini, V., & Paci, P. (2015). *Poverty Reduction in Ghana*. Washington: World Bank, Washington, DC. Retrieved from <https://openknowledge.worldbank.org/handle/10986/22732>
- Ofori-Atta, A., Read, U., & Lund, C. (2010a). A situation analysis of mental health services and legislation in Ghana: challenges for transformation. *African Journal of Psychiatry*, 13(2). <http://doi.org/10.4314/ajpsy.v13i2.54353>
- Ofori-Atta, A., Read, U., & Lund, C. (2010b). A situation analysis of mental health services and legislation in Ghana: challenges for transformation. *African Journal of Psychiatry*, 13(2). <http://doi.org/10.4314/ajpsy.v13i2.54353>
- Omigbodun, O. (2008). Developing child mental health services in resource-poor countries. *International Review of Psychiatry*, 20(3), 225–235. Retrieved from <http://10.1080/09540260802069276>
- Patel, V., Jenkins, R., & Lund, C. (2012). Putting evidence into practice: The plos medicine series on global mental health practice. *PLoS Medicine*, 9(5), 9–10.

<http://doi.org/10.1371/journal.pmed.1001226>

- Paula, C. S., Lauridsen-Ribeiro, E., Wissow, L., Bordin, I. A. S., & Evans-Lacko, S. (2012). How to improve the mental health care of children and adolescents in Brazil: Actions needed in the public sector. *Rev Bras Psiquiatr. DESCRIPTORS Child, Adolescent, Mental Health Community Mental Health Services; Primary Health Care*, 34(3), 334–341. <http://doi.org/10.1016/j.rbp.2012.04.001>
- Petersen, I., Swartz, L., Bhana, A., & Flisher, A. J. (2010). Mental health promotion initiatives for children and youth in contexts of poverty: the case of South Africa. *Health Promotion International*, 25(3), 331–41. <http://doi.org/10.1093/heapro/daq026>
- Rahman, A., Mubbashar, M., Harrington, R., & Gater, R. (2000). Developing child mental health services in developing countries. *Journal Of Child Psychology And Psychiatry, And Allied Disciplines*, 41(5), 539–546. Retrieved from <http://proxy.lib.sfu.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=mnh&AN=10946747&site=ehost-live>
- Raja, S., Wood, S. K., de Menil, V., & Mannarath, S. C. (2010). Mapping mental health finances in Ghana, Uganda, Sri Lanka, India and Lao PDR. *International Journal of Mental Health Systems*, 4(1), 1–14.
- Raja, S., Underhill, C., Shrestha, P., Sunder, U., Mannarath, S., Wood, S. K., & Patel, V. (2012). Integrating mental health and development: A case study of the basic needs model in Nepal. *PLoS Medicine*, 9(7), 1–7. <http://doi.org/10.1371/journal.pmed.1001261>
- Raja, S., Wood, S. K., de Menil, V., Mannarath, S. C., Saraceno, B., Ommeren, M. van, ... Whiteford, H. (2010). Mapping mental health finances in Ghana, Uganda, Sri Lanka, India and Lao PDR. *International Journal of Mental Health Systems*, 4(1), 11. <http://doi.org/10.1186/1752-4458-4-11>
- Read, U., Adiibokah, E., & Nyame, S. (2009). Local suffering and the global discourse of mental health and human rights: an ethnographic study of responses to mental illness in rural Ghana. *Globalization and Health*, 5, 13. <http://doi.org/10.1186/1744-8603-5-13>
- Read, U. M., & Doku, V. C. K. (2012). Mental health research in Ghana: a literature review. *Ghana Medical Journal*, 46(2 Suppl), 29–38. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3645145&tool=pmcentrez&rendertype=abstract>
- Reichenbach, L. (2002). The Politics of Priority Setting for Reproductive Health: Breast and Cervical Cancer in Ghana. *Reproductive Health Matters*.
- Republic of South Africa. (2015). *NATIONAL YOUTH POLICY*. Republic of South Africa.

- Roberts, D. M., Asare, P. J. B., Mogan, C., Adjase, D. E. T., & Osei, D. A. (2013). The mental health system in Ghana, (June), 1–75.
- Roberts, H. (2001). A way forward for mental health care in Ghana? *Lancet (London, England)*, 357(9271), 1859. [http://doi.org/10.1016/S0140-6736\(00\)05020-0](http://doi.org/10.1016/S0140-6736(00)05020-0)
- Roberts, M., Mogan, C., & Asare, J. B. (2014). An overview of Ghana's mental health system: results from an assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS). *International Journal of Mental Health Systems*, 8(1), 1–13. <http://doi.org/10.1186/1752-4458-8-16>
- Sachs, J., & McArthur, J. (2005). The Millennium Project: a plan for meeting the Millennium Development Goals. *The Lancet*, 365(9456), 347–353. [http://doi.org/10.1016/S0140-6736\(05\)17791-5](http://doi.org/10.1016/S0140-6736(05)17791-5)
- Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., ... Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *Lancet (London, England)*, 370(9593), 1164–74. [http://doi.org/10.1016/S0140-6736\(07\)61263-X](http://doi.org/10.1016/S0140-6736(07)61263-X)
- Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *Lancet (London, England)*, 370(9590), 878–89. [http://doi.org/10.1016/S0140-6736\(07\)61239-2](http://doi.org/10.1016/S0140-6736(07)61239-2)
- Tabi, M. M., & Frimpong, S. (2003). HIV infection of women in African countries. *International Nursing Review*, 50(4), 242–250. <http://doi.org/10.1046/j.1466-7657.2003.00206.x>
- Uman, L. S. (2011). Systematic reviews and meta-analyses. *Journal of the Canadian Academy of Child and Adolescent Psychiatry = Journal de l'Académie Canadienne de Psychiatrie de L'enfant et de L'adolescent*, 20(1), 57–9. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/21286370>
- Wahab, H., & Assensoh, A. (2008). A Historical-Cum-Political Overview of Ghana's National Health Insurance Law. *African and Asian Studies*, 7(2), 289–306. <http://doi.org/10.1163/156921008X318754>
- WHO. (2010). *Ghana: Health Statistics Profile*. Retrieved from <http://www.who.int/gho/countries/gha.pdf?ua=1>
- World Health Organization. (2003). *ORGANIZATION OF SERVICES FOR MENTAL HEALTH*. Geneva.
- World Health Organization. (2005). *Child and adolescent mental health resources: Global concerns: implications for the future*. Geneva. Retrieved from

http://www.who.int/mental_health/resources/Child_ado_atlas.pdf

World Health Organization (WHO). (2007). *Ghana: a very progressive mental health law. The country summary series.* Retrieved from http://www.who.int/mental_health/policy/country/GhanaCountrySummary_Oct2007.pdf

World Health Organization (WHO). (2011). *WHO-AIMS REPORT ON MENTAL HEALTH SYSTEM IN GHANA.* Retrieved from http://www.who.int/mental_health/who_aims_country_reports/ghana_who_aims_report.pdf

Appendix A.

Figure 1 Population Pyramid Graph, Ghana 1970-2030





