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The criteria for diagnosing mental illness varies person-by-person and culture-by-culture. Once diagnosed with a mental illness, a person can expect to face discrimination, whether subvert or advert, throughout their lives. In Ghana, accepted religious and spiritual beliefs institutionalize the stigmatization of the mentally ill. To battle this stigma, and fight for the improvement of care for the mentally ill, it is necessary to understand the current situation of mental health care and to understand the cultural forces behind its stigmatization.

Mental illness is predicted to afflict one out of every four people worldwide at some point in a person's life.[1] Mental illness has a positive correlation to the development of chronic health problems and can be blamed for 30% of years of life lost worldwide.[2] Mental health care requires specialized staff and separate hospitals to treat patients and there is a large stigma associated with mental illness. The WHO classifies Ghana as a lower middle-income country (LMIC), but Ghana fails to meet many of the average statistics of other LMICs in terms of mental health care. Ghana struggles with inadequate facilities and human resources, uneven distribution of resources, and stigma associated with mental illness. In conjunction with the formal system of mental health care, the informal practice of care by religious and spiritual leaders plays a critical role in the care of the mentally ill in Ghana. Religion and spirituality are strongly associated with both the cause of mental illness as well as the treatment of mental illnesses. The following paragraphs will discuss the structure of the formal system of mental health care and address its shortcomings, they will discuss Christian and traditional religious ideas and how these beliefs and values pertain to mental health, and finally will discuss the implications of both systems playing an active role in communities.

In 2012 the Ghana legislature passed the "Mental Health Law" aimed at updating standard practice to conform to international ideas of "best practice standards for mental health practice and legislation."[3] The law reorganized the bureaucratic organization of mental health care in order to make mental health care more of a priority with the Ghana Health Services and more integrated within the Ministry of Health. The law, following the advice of current research, emphasizes community-level facilities and interventions rather than institutional facilities such as state-sponsored mental hospitals.[4] The new law has promised to drastically improve the status of psychiatric patients in Ghana; however, it may take a long time to fully implement the policy. In the meantime, many patients fall through the cracks.

In Ghana, large numbers of mentally ill people go untreated and the distribution of resources is uneven by region. There is no comprehensive data available on the prevalence of mental illness, but it is estimated that ten percent of a given population is afflicted with mental illness, which is 2.4 million people. In 2012, the Kintampo Project conducted a comprehensive study of the mental

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health system to assess mental health services of the previous year. In 2011, 67,780 people were treated for mental illness in a clinical setting, which equates to 236 per 100,000 people in population; LMICs' average is 688 per 100,000 people. In short, "If you are a Ghanaian with a mental illness, there is only a two percent chance you'll receive any treatment. Local mental health services simply don't exist for most people."[5] There are three mental hospitals in Ghana, all located along the southern coast in the Greater Accra (G/A) and the central regions. The density of psychiatric beds in the G/A region is 7.3 times that of the rest of the country. The number of beds made available to psychiatric patients by region declines drastically from the region with second most (central: 13.8/100,000) to third most (Ashanti: 2.1/100,000) and several regions reported having zero psychiatric beds. The upper east region ranks third, the upper west region fourth, and the eastern region ranks fifth in the number of patients treated in outpatients per 100,000 (371, 265, 231 respectively) yet all three regions report having zero psychiatric beds.

Human resources in mental health are sparse and poorly distributed by region and within the formal system itself.

There are eighteen psychiatrists (0.07/100,000) and 1,068 registered mental health nurses, making a total of 4.9 professionals per 100,000 people. In comparison, the total number of mental health professionals working per 100,000 people in other LMICs is 6. These mental health professionals are concentrated in certain regions without regard to the number of psychiatric patients that these regions are treating. For example, the upper east region treats the third most psychiatric patients (371/100,000), yet has a relatively low number of mental health staff (1.65/100,000). Meanwhile, the northern region treats the third smallest number of psychiatric patients (154/100,000) yet has a relatively high concentration of mental health staff (3.21/100,00). This disconnect between available resources and the needs of the different regions is the result of poor governmental planning and results in the reduction of access of mental health services. Furthermore, the human resources and resources (beds) are generally located near urban centers, so inhabitants of rural regions are disproportionately affected by the lack of access to mental health care services. Human resources are also distributed unevenly throughout the system. A total of 67,732 people were treated for mental illness by the formal system in 2011. 57,404 of these people were treated in outpatient services and 7,933 were treated in one of the three state-sponsored mental hospitals. Even though the majority of patients were treated in outpatient departments, only 287 registered mental health nurses (RMNs) worked in outpatient services, while the majority, 748 RMNs, worked at the mental hospitals.

Despite progressive public policy aimed at addressing the serious gaps in the treatment of the mentally ill, Ghana fails to deliver adequate access to mental health services. This failure is rooted in inadequate government funding. Only 1.4 percent of the total health budget was allocated to mental health, and virtually all of this money went to finance the state-sponsored institutional facilities. The inadequate access to mental health services is also a product of the misallocation of health care resources and human resources by region and within the system. Regions like the upper west, upper east, and eastern regions, that treated some of the most patients, received the least amount of resources and regions like the northern region, that treated some of the least amount of patients, had a high concentration of mental health professionals. The uneven allocation of financial resources directly contradicts the goal of the new public policy, which is to expand the community-level facilities rather than the institutional facilities.

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Working outside the formal system of mental health care, religious and spiritual leaders treat mental illness at a community level. Mental illness is heavily steeped in ideas of spirituality and divine intervention; many people will seek treatment from religious or spiritual healers instead of, or concurrently with, biomedical treatment. As the government averts its focus from institutional facilities to community-level facilities, it is important to understand how mental illness and the treatment of mental illness is perceived at a community level. The religious ideas of the citizens have a lot to do with their perceptions of mental illness and their treatment seeking behaviors.

Ghana is an extremely religious nation; 71.2 percent of Ghanaians practice Christianity, 17.6 percent practice Islam, and 5.2 percent adhere strictly to a traditional religion.[6] Despite the low percentage of people reporting traditional religions as their primary religions, many practice traditional religions along with Christianity or Islam. Traditional religion and its beliefs, values, and

practices are prevalent in society and are an important part of Ghanaian culture.[7] This is reflected in the popularity of syncretic religions, such as Pentecostal Christianity, which combine Christianity and ideas of spirituality common among traditional religions. In fact, Pentecostal and charismatic sects of Christianity make up the largest percent of Christians in Ghana at 28.3 percent.[8]

Portuguese traders first introduced Christianity to the people of Ghana during the 15th century. These early settlers brought Roman Catholicism to Ghana, but many different sects of Christianity would soon follow as Western European traders and missionaries flocked to the Gold Coast.[9] The missionaries arrived with educational reforms and western biomedical science. Thus, Christianity in Ghana has had a long-standing relationship with medicine and healing. Furthermore, Christianity itself is associated with healing. Jesus is described in the Bible as a healer, curing cases of leprosy and other sicknesses. A passage from Matthew 15:28 illustrates the association between the Christian faith and healing: "Then Jesus answered and said to her, 'O woman, great *is* your faith! Let it be to you as you desire.' And her daughter was healed from that very hour."[10]

In the 1920s, Christian prayer camps began to emerge to treat physical and mental ailments. A religious idealist who is a self-proclaimed prophet with healing powers generally heads these prayer camps. According to the Human Rights Watch, "The main difference between prayer camps and the Catholic or Protestant churches, according to a Christian leader, is that 'prayer camps are more of charismatic and Pentecostal churches, and they specifically believe in the power of miracles, consultation with angels, and spiritual healing."[11] There are now hundreds of Christian prayer camps throughout the country.[12] The Kintampo Project surveyed ten faith-based clinics that in total treated 1,253 patients. While there is no comprehensive data on the number of patients treated in prayer camps, if only ten treated 1,253 in one year then the number must be substantial when considering the hundreds of prayer camps in Ghana.

Christian prayer camps operate outside of the formal system without any supervision by a physician or the government. Fifty-six percent of the prayer camps surveyed in the Kintampo Project reported treating patients with medication acquired from the pharmacy. This is a dangerous practice without the supervision of a physician because of the possibility of harmful drug interactions, overdoses, allergic reactions, and other complications involved with administering prescription medication. Even more disturbing are the human rights abuses that have been well documented by international organizations such as the Human Rights Watch. The Human Rights Watch published a report on Christian prayer camps in Ghana entitled "Like a Death Sentence: Abuses Against Persons with Mental Illness in Ghana." In this report, overcrowding, unhygienic living quarters, chaining inside and outdoors, lack of shelter, and the denial of food were conditions found to occur in many of the Christian prayer camps visited by the NGO. One patient from Mount Horeb Prayer Camp describes how "You can't have a good bath with a chain. We shit here and they don't come to clean up.' He added, 'It smells a lot inside here. I don't know when I will leave this place."[13] The Human Rights Watch reports, "Those who were chained in stalls at Edumfa and Mount Horeb Prayer Camps had to shower in the stalls where they slept and ate. Aisha, a 56-year-old woman at Mount Horeb Prayer Camp, told Human Rights Watch, 'I bathe only two times a week, but I want to bathe every day.'"[14] Mount Horeb prayer camp later reported to *The Lancet* that it had not used chains for years, contradicting the overwhelming evidence against this claim. These types of practices are not conducive to treating mental illness, and many people wished to leave; however, "people are allowed to leave only when the prophet considered them ready to be discharged."[15] Unfortunately, for mental health patients in Ghana, these types of conditions were also found in the state-sponsored mental institutions. However, in this case the Mental Health Law promises to reform some issues like involuntary detention, chaining, and hygiene. The new law will have no effect on the treatment of the mentally ill in Christian prayer camps.

Traditional healers also play a large role in the informal primary care of mentally ill people. Traditional religion is the indigenous religion of the African people so it is derived long before Christianity was introduced to the African continent. Traditional religions are passed down from generation to generation and are an important part of African culture because they allow people to identify with their ethnic origins and their family heritage.[16] There are many different traditional religions in Ghana and throughout the African continent but there are a few

themes, beliefs, and values that are common among most traditional religions. These include: the belief in a supreme, omnipotent God, the removal of the supreme God from daily worship, the idea that lesser gods take residency in objects and places, the recognition of the spirits of the ancestors, the idea that the spirit world of the ancestors is as real as the living world, and the roles of chiefs, elders, religious leaders in balancing the spirit and the living world.[17] These common themes reflect a strong belief in spirituality and direct, tangible action by the Gods. A product of this belief system is the perception of disease as the result of divine intervention. As a result, traditional religious and spiritual leaders assume the duty of treating illness, both physical and mental.

Komla Tsey identifies three major paths to becoming a traditional healer. One becomes a traditional healer either through an apprenticeship, self-learning, or because of a "calling." Rather than categorizing healers based on how they became healers, it is more useful to categorize the traditional healer based on whether or not they practice "spiritually based" or non-spiritually based" healing. Spiritually based healers claim to have received a calling from the gods beckoning them to the practice, while non-spiritually based practitioners report rational reasons like the need for supplemental income.[18] It is the purview of the spiritually based healers to treat mental illness. Spiritual healers report consulting the Gods for treatment advice for each new case they receive.[19] To spiritual healers, mental illness is a "possession by evil spirits. They [mental illnesses] are 'disturbances in the relationship between people and divinity, [and] divine punishment for past actions...."[20] Thus, the treatment of mental illness by these spiritual healers often focuses on driving out evil spirits through worship, ritual, and herbal remedies.

The conditions and human rights status of patients of traditional healers is less researched because they tend to operate on a much smaller, local scale than the Christian prayer camps. Komla Tsey's report on the members of the Botoku Branch of the Traditional Healers Association highlights this contrast between the system of traditional healers and Christian prayer Camps. Tsey spent one year in Botoku, a small village 200 km from Accra in the Volta region. By all measures, Botoku is an average rural village in Ghana that "supplements subsistence farming with fishing and trade."[21] Tsey interviewed twelve of the sixteen members of the Traditional Healers Association around Botoku. Tsey found that the number of patients being treated or cared for by traditional healers ranged from ten to thirty at a given time. Among the twelve practitioners interviewed, only three provided "residential services."[22] So the majority of people being treated by traditional healers are seen in their own home, significantly reducing the risk of human rights abuses. The three traditional healers who did offer residential services were all spiritually based healers and the majority of their patients were mental health patients. Tsey did not note any human rights abuses or maltreatment of these patients, in fact quite the opposite; he describes the residential services involving "the patient and the carer(s) moving in to live as part of the practitioner's extended family."[23]

There is a clear contrast between the practice of Christian prayer camps and that of traditional healers. While both operate at the local level, Christian prayer camps do so on a larger scale and can be seen as more regional treatment centers. Traditional healers are most active at the village level and tend to limit the number of patients treated, mainly due to time and resource restraints. Additionally, Christian prayer camps almost always involve the admittance of patients into residential units, oftentimes indefinitely. This exposes Christian prayer camps to committing human rights abuses associated with unhygienic conditions and cramped living quarters because of the financial incentive to admit as many patients as possible. On the other hand, admitting patients into residential units is a practice typically reserved to spiritual healers in the treatment of the mentally ill, and patients are seen as joining the healer's extended family.

Both types of informal care provide spiritual and religious treatment for psychological disorders, supplying a strong demand for such treatment of mental illness. The current formal system of mental health care fails to deliver adequate care to mentally ill patients on a community level, so the Christian and spiritual healers occupy an important position in the primary care of mental health patients. In addition to the demand created by a lack of biomedical resources, many people will choose to visit a Christian or spiritual healer rather than visit a regional hospital. This decision may stem from financial reasoning, but oftentimes it is because of religious and cultural beliefs. The spiritual nature of disease and the power of miracles are common beliefs that cause people to view mental illness as the product of divine intervention (which

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a hospital will not be able treat) which necessitate the consultation of a religious or spiritual leader.

Inadequate or improper systems of care place a strong economic burden on societies.[24] The government allocates 1.4% of the national health budget, or GhC 4,516,163, for mental health expenditures; however, the real cost to society is derived from, "lost employment and reduced productivity, impact on families and caregivers, levels of crime and public safety, and the negative impact of premature mortality."[25] Mental illnesses are positively correlated with greater risks of developing chronic illnesses, experiencing acute health problems, and substance abuse disorders, placing further burden on the public insurance system of Ghana.[26] It is in the best interest of politicians and government officials to address the inadequate system of mental health because it is contributing to a significant drain on government resources. This introduces the question, what can be done to improve the conditions and health of the mental health patients in Ghana?

From an economic standpoint, it is clear that Ghana will have to spend more money on the formal mental health care system if it is to carry out the new policy dictated by the Mental Health Law and expand services on a community level. The Ghanaian government offers free public health insurance and guarantees all mental health care services for free, so where will the money come from? Some western organizations and nations might argue that the best way is to privatize the system and allow the private market to finance the initiative. People of the Ghanaian government and health care administration might say that they need more money in aid to accomplish their goals. Both systems have their advantages and disadvantages. Privatization would take the burden off of the federal government, but could lead to expensive health care and cause many people to be unable to afford health care. Aid will help finance the initiative but is a short-term solution to a chronic problem. Accepting aid money year after year to pay for a necessary social service leads to chronic dependence on aid which will hurt the Ghanaian government in the long run. However, if the government decides to finance the initiative, they should make use of pre-existing community resources (traditional and Christian healers) by integrating the informal system into the formal system.

The government should begin regulating clinics by mandating that clinics and the clinics employees register with the government. This will allow the government to maintain an oversight over the clinics to ensure that no human rights abuses occur and to offer education programs to the people working in the clinics so that the patients are receiving the best possible care. Clinics that do not comply with regulation should be immediately shut down. Another possible solution is to form an association between regional hospitals and faith-based clinics. This would spread the access of mental health care through the formal system, ensure the safety of patients of faith-based clinics, and create a system where people do not have to choose between faith and formal medicine.

It is important to consider the cultural environment in which policy and interventions are being enacted. There are many other players besides the government working in Ghana, which include NGOs from western nations. Western nations tend to have greater faith in biomedical science than religion, and so their initiatives will promote medical care over religious treatment. But is this what local communities need? Mental illness is a unique field of

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medicine in that the diagnosis of psychological disorders are ambiguous, signs and symptoms vary across cultures, and the efficacies of treatments of certain disorders are widely debated. Westerners may promote the application of biomedical sciences to treat mental illness, but this may not always be the best course of action. Research has shown that patient satisfaction with treatment and care has led to better health outcomes. Stewart et al. showed that increased "patient-centered communication," lead to better recovery, better emotional health, and less needs for further medical attention.[27] If a patient wholeheartedly believes they are afflicted with a malevolent spirit then providing them with that course of treatment may be what is necessary (perhaps alongside biomedical treatment) for a positive health outcome. Western NGOs and other organizations working to enact interventions at a community level should keep in mind one thing: Africa is not worse, backwards, or behind Western culture; it is different and actions should reflect this by conforming to local culture and community needs.