Mental Health Research in Ghana Post 2012: A systematic review

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INTRODUCTION

Societies across the globe struggle to care for people with mental illness. It has historically been neglected and absent from within Africa's health and development policy agenda. The World Psychiatric Association suggested that the development of mental health programs is impeded in Africa because of the scarcity of economic and staff resources, lack of awareness, and the stigma associated with seeking psychiatric care (Fournier, 2011).

There are 25.9 million people living in Ghana and there are 2.8 million Ghanaians living with mental illnesses, such as schizophrenia/psychosis, depression, suicide and self-harm and substance misuse (Avenue, H. R. W., 2018; Fournier, 2011). However, only 3.4% of the total health budget is dedicated to psychiatric hospitals (Roberts et al., 2014).

The 2012 Mental Health Act was created and implemented in order to completely change the mental health systems and infrastructure that previously existed in Ghana. The main goal was to ensure the rights and quality of treatment of those with mental illness and to enact changes to the organization, provision, and funding. (Walker & Osei, 2017).

Ghana has come a long way in creating an effective and equitable mental healthcare system by implementing the 2012 Mental Health Act, but still has a long way to go in reducing the social disparities and stigma that prevents the community from accessing the care they need.

LEARNING OBJECTIVES

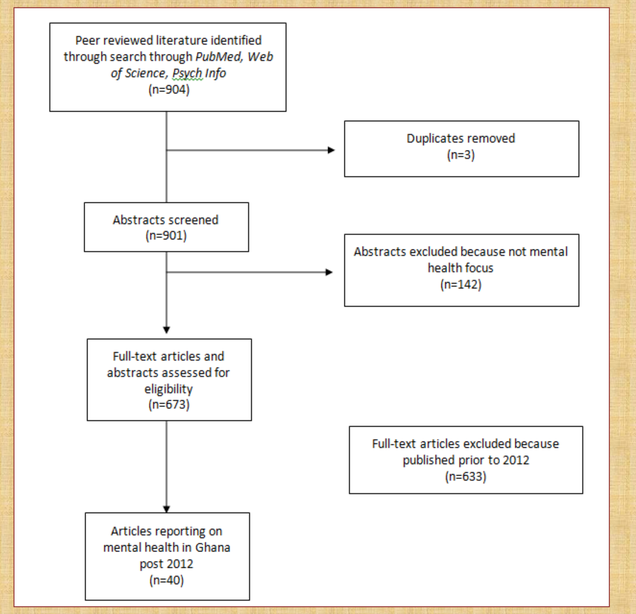
- Understanding the disparities in treatment and care for mental illness in Ghana post implementation of The 2012 Mental Health Act
- Offer next steps for mental health policy
- Understanding the cultural attitudes and beliefs toward causes of mental illness and the mentally ill

Figure 1. Mental Health Authority from Ankaful Psychiatric Hospital, Central Ghana

METHODS

A comprehensive, systematic detail strategy was undertaken to search for all articles related to mental health post 2012 in Ghana. Systematic review followed the PRISMA guidelines (see Figure 2). Inclusion criteria included being published post 2012 and examined mental health post 2012. Key words such as mental health, Ghana, mental health act, treatment, plus several similar terms were used.

Figure 2. PRISMA Diagram



RESULTS

A total of forty articles published after 2012 were identified. Hundred-forty two non-mental health papers were excluded and 633 were excluded that were published prior to 2012. Articles were grouped under the most relevant topics however there was overlap in some papers (see Table 1).

Table 1. Reviewed papers by topic

Themes	Number of Articles	Author(s)/year
Barriers to Mental Health Care	18	Addo et al. (2013); Adjorlolo (2016); Adjorlolo, Abdul-Nasiru et al. (2018); Agyapong et al. (2016); Ame et al. (2016); Andoh-Arthur et al. (2015); Badu et al. (2018); Canavan et al. (2013); Dzator (2013); Edwards (2014); Greif et al. (2015); Ibrahim et al. (2016); Jack et al. (2015); Oppong et al. (2016); Sottie et al. (2018); Tawiah et al. (2015); Thapa et al. (2014); Wilson et al. (2017)
Increased Access to Care	16	Abdulmalik et al. (2014); Agyapong et al. (2016); Ahuja et al. (2016); Ame et al. (2016); Badu et al. (2018); Osafo et al. (2015); Nartey et al. (2019); Ben-Zeev et al. (2018); Esan et al. (2014); Ibrahim et al. (2016); Jack et al. (2015); Kpobi and Swartz (2018); Osafo (2016), Agyapong et al. (2016); Yendork, Kpobi et al. (2016); Schneider et al (2016).
Beliefs/Attitudes towards Mental Illness	21	Adjorlolo, Abdul-Nasiru et al. (2018); Stefanovic et al. (2016); Andoh et al. (2015); Asante et al. (2015); Yendork, Brew et al. (2018); Opare-Honaku and Utsey (2017); Makanjuola et al. (2016); Lyons et al. (2015); Bonsu et al. (2019); Edwards (2014); Greif et al. (2015); Gyamfi et al. (2018); Jack et al. (2015); Kpobi and Swartz (2018); Kopbi, Swartz et al. (2018); Kpobi and Swartz (2018); Opare (2014); Sottie et al. (2018); Tawiah et al. (2015); Walker and Osei (2017); Wilson et al. (2017)

Barriers to Mental Health Care

Seventeen studies examined and addressed potential barriers to accessing and receiving mental health care in the Ghanaian population. Three studies addressed systemic barriers such as policies, care facilities, and pathways to care (Agyapong et al., 2016, Ibrahim et al., 2016, & Badu et al., 2018). One study found that the household cost for the 3 months of care were $35,518 and that most drugs are not covered in that price (Addo et al., 2013) while another found that the availability of medications made consistent management of mental illness more difficult (Oppong et al., 2016). Three studies investigated the opinions of mental health professionals and found that constant discrimination against those with mental illness may discourage people from pursuing care (Adjorlolo, 2016, Sottie et al., 2018, & Tawiah et al., 2015). Two studies found that there was a correlation between low SES and poverty and an increased prevalence of psychological disorders (Canavan et al., 2013, & Jack et al., 2015). Additionally, these studies found that those who were more distressed were less likely to be employed indicating that a policy that protects the employment status of those with mental illness could potentially eliminate a barrier to care.

Attitudes and Beliefs toward Mental Illness

Twenty-one studies examined what the cultural attitudes were towards those with mental illness and what the beliefs of the root causes of mental illness were. Six of these articles directly addressed what the dominant believe for the cause of mental illness was and found that Ghanaians subscribe to several beliefs about the causes of illness. The largest of these was spiritual in nature and was brought about by curses, evil spirits, immoral behaviors, or was some sort of social retribution (Stefanovic et al., 2016, Yendork, Brew et al., 2018, Opare-Honaku and Utsey, 2017, Kpobi and Swartz, 2018, Opare, 2014, & Kpobi, Swartz et al., 2018). This religious behavior has even been amplified to the point of confining patients into "prayer camps" while beating and starving them as punishment (Edwards, 2014). One of these studies found that 98% of Ghanaians don't receive any kind of treatment largely due to these spiritual beliefs and the stigma that surrounds it (Opare-Honaku and Utsey, 2017). Four articles investigated stigma surrounding those with mental illness and how it impacts them. Two studies found that stigma not only affects those with the illness but also their families and caregivers and extends into areas such as employment and education (Bonsu et al., 2019 & Tawiah et al., 2015). Two other studies found that stigma also extends to those going into the mental health field. Stigma can adversely affect medical and social work students and can alter their views towards the mentally ill and can cause them to drop out of the field all together. Having anti-stigma education as part of the curriculum can help counteract this influence (Lyons et al., 2015 & Sottie et al., 2018).

Increased Access to Care

Fifteen articles explored possible enablers for access to adequate mental health care and treatments. Three studies found that existing policies and care systems such as task-shifting referral system, and the 2012 Mental Health Act vastly increase the likeliness of accessing mental health care (Badu et al., 2018, Agyopong et al., 2016 & Nartey et al., 2019). Three studies investigated the feasibility of combining religious practices with biomedical care. They argued that since a large portion of the community believes in a spiritual/religious origin of mental illness, integrating the traditional faith-based care and biomedical style of care would be a best practice for providing holistic care and reducing stigma for seeking care (Osafa et al., 2015, Jack et al., 2015, & Osafu, 2016). One study examined using an mHealth approach to mental healthcare in order to overcome the problems of limited infrastructure and mental health workers. This study found that community stakeholders from all sectors were open to using mHealth and that a combination of audio and video content would be best to avoid issues with limited literacy (Ben-Zeev et al., 2018). Another study developed a pilot program called "The Mental Health Leadership and Advocacy Program" (mhLAP) that was designed to train participates on mental health advocacy and to form a group a group of stakeholders that would meet with policy-makers. This group would be the voice for the community during the design and implementation of mental health legislation (Abdulmalik et al., 2014).

CONCLUSIONS

A total of 40 studies on Ghana post the 2012 Mental Health Act published after 2012 were reviewed. The studies reviewed have been small in scale and of limited generalizability. However, they did provide important information into the current state of mental health care in Ghana, and suggested directions for increase care. Based on this review, we suggest the following priorities for mental health research in Ghana:

- Increase anti-stigma education and mental health training
- Integrating biomedical and traditional faith based care for mental health
- More mHealth related interventions that are culturally accessible and comprehendible

Given the huge burden of mental illness suggested by the WHO in Ghana, there is a convincing case for international funding for mental health research to provide a better foundation for directed and culturally appropriate interventions.

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