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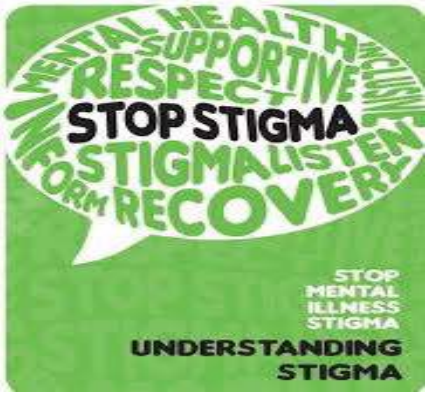

PERFORMANCE AUDIT REPORT OF THE AUDITOR-GENERAL ON MENTAL HEALTH MANAGEMENT AND CARE DELIVERY IN GHANA

This report has been prepared in compliance with Article 187(2) of the 1992 Constitution of Ghana and Section 13(e) of the Audit Service Act, 2000 (Act 584) for submission to Parliament in accordance with Section 20 of the Act.

Johnson Akuamoah Asiedu
Auditor-General
Ghana Audit Service
01 March, 2022

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TRANSMITTAL LETTER

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1 March 2022

Dear Rt. Hon. Speaker,

PERFORMANCE AUDIT REPORT OF THE AUDITOR-GENERAL ON MENTAL HEALTH MANAGEMENT AND CARE DELIVERY IN GHANA

I have the honour, in accordance with Article 187(2) of the 1992 Constitution of Ghana, Sections 13(e) and 16 of the Audit Service Act, 2000 (Act 584) to submit a performance audit report on Mental Health Management and Care Delivery in Ghana.

2. A survey conducted in 2012 by Mark Roberts et al on Ghana's mental health system showed that there were an estimated 2.4 million people with mental health problems of which 67,780 (i.e., 2.8%) received treatment. Also, according to WHO report KEY FACTS 2019, out of the 30.4 million population of Ghana, 650,000 are suffering from severe mental disorders and a further 2.2 million, are suffering from a moderate to mild mental disorders.

3. The Auditor-General commissioned the audit to determine whether Mental Health Authority (MHA) is ensuring that patients who need mental health care get the required treatment.

4. We carried out the audit at the offices of MHA in Accra. We reviewed documents, carried out observation, interviewed key personnel and visited treatment facilities from the three main psychiatric hospitals in Ghana, four teaching hospitals, five regional hospitals and 15 district hospitals as well as

forty selected traditional and faith-based healers, covering the period 2016 to 2020.

5. We noted that although Community Care Department (CCD) planned for awareness creation activities, the plans were not based on any data gathered, analysed and categorised under major causes of mental health to enable effective messaging and targeting of awareness dissemination.

6. The CCD could not carry out the activities it planned in each of the six years, except occasional use of slots from electronic media for awareness creation on annual international day celebrations such as world suicide day and world epilepsy day.

7. The teaching hospitals and the psychiatric treatment facilities executed awareness creation activities but failed to record the activities to inform decisions on ensuing programmes.

8. Our audit also revealed that, non-availability of Psychotropic medicines in hospitals is hampering the treatment of mental health patients. Community psychiatry nurses at the municipal and district hospitals are compelled to prescribe medicines to patients who buy them on the open market for use at their own cost and the risk that these medicines did not match the ones prescribed by mental health officers.

9. During the audit, we found that there is a shortage of medical health professional leading to many alternative mental health treatments by Traditional and Faith-Based Healers. The activities of these traditional and Faith based healer are not monitored by MHA.

10. I have made recommendations to MHA, the details of which is in this report to bring about improvement in their activities.

11. I also recommended to MHA to collaborate with the Ministry of Finance, Health, and the Central Medical Stores to improve the supplies of medicines and on the use of the Mental Health Fund.

Yours faithfully,

JOHNSON AKUAMOAH ASIEDU
AUDITOR-GENERAL

THE RT. HON. SPEAKER
OFFICE OF PARLIAMENT
PARLIAMENT HOUSE
ACCRA

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LIST OF ABBREVIATIONS

CCD	- Community Care Department
CHAG	- Christian Health Association of Ghana
CHPS	- Community Health Planning Services
CPHOs	- Community Psychiatry Health Officers
CMS	- Central Medical Stores
DDPS	- Deputy Director Pharmacy Services
DFID	- Department for International Development
DMHOs	- District Mental Health Officers
DPU	- District Psychiatry Unit
GHS	- Ghana Health Service
ICD	- Institutional Care Department
ICT	- Information Communication Technology
IGF	- Internally Generated Fund
L.I	- Legislative Instrument
MHA	- Mental Health Authority
NHIS	- National Health Insurance Scheme
OPD	- Outpatient Department
PPME	- Policy, Planning, Monitoring, and Evaluation
RMHOs	- Regional Mental Health Officers
TFBS	- Traditional and Faith-Based Healers
WHO	- World Health Organisation

EXECUTIVE SUMMARY

Mental Health Authority is the body mandated to oversee mental health service delivery in Ghana. The Authority is responsible for the promotion and implementation of mental health policies in a bid to provide culturally appropriate, humane, and integrated mental health care throughout Ghana.

2. Mental health care is services devoted to the treatment of mental illnesses and improvement of mental health in people with mental disorders or problems. A survey conducted in 2012 by Mark Roberts et al on Ghana's mental health system showed that there were an estimated 2.4 million people with mental health problems of which 67,780 (i.e., 2.8%) received treatment. Also, according to WHO report KEY FACTS 2019, out of the 30.4 million population of Ghana, 650,000 are suffering from severe mental disorders and a further 2.2 million, are suffering from a moderate to mild mental disorders.

3. The purpose of this audit was to determine whether Mental Health Authority (MHA) is ensuring that patients who need mental health care get the required treatment. The audit team reviewed documents, carried out observation, interviewed key personnel and visited treatment facilities from the three main psychiatric hospitals in Ghana, four teaching hospitals, five regional hospitals and 15 district hospitals as well as forty selected traditional and faith-based healers. The audit focused on awareness creation of the public on care and treatment of mentally ill patients in Ghana, monitoring of mental health activities by the MHA and the operation of the mental health fund. Although the MHA has put in place programmes (durbars, outreaches, home visits among others) and activities to aid the delivery of mental health care service in the country, mental health care in Ghana has been fraught with several challenges leading to depreciation in care. These are:

3.2.1 MHA did not plan adequately for awareness creation activities

4. We noted that the Community Care Department (CCD) planned for awareness creation activities, but the plans were not based on any data of major causes of mental health to enable effective messaging and targeting of awareness dissemination. Also, the awareness creation plans by the CCD did not address the categories of mental health illness to enhance the assessment of the impact

of its awareness creation programmes. Though the three psychiatric hospitals (Accra, Pantang and Ankaful), prepared plans with budgets and carried out the awareness creation programmes on mental health through their community psychiatric units these awareness creation programmes by the treatment facilities did not make annual projections on targeted mental health education programmes to address the causes of mental health challenges (drug abuse, long term stress, long term physical condition, neglect, feelings of loneliness or isolation among others). We therefore recommend the MHA to:

- ensure that, awareness creation plans by psychiatric treatment facilities is comprehensive to include the type of message, the means of carrying out the message, the form it is to take and where it should be delivered in addition to responsibility roles for implementation.
- ensure that, psychiatric professionals at all levels of care are trained on how to develop detailed plans and budgets to ensure effective awareness creation on mental health.

3.2.2 Non-execution of mental health awareness creation plans by MHA

5. The Community Care Department (CCD) of the MHA planned to inform the public on mental health through community durbars, health walks, radio talks, visits to schools, churches, and mosques, among others. The CCD could not carry out the activities it planned in each of the five years. However, the Authority was able to occasionally lobby for slots from the electronic media for awareness creation on annual international day celebrations such as world suicide day and world epilepsy day. The teaching hospitals and the psychiatric treatment facilities executed awareness creation activities but failed to record the activities to inform decisions on ensuing programmes.

6. We recommended that the CCD of MHA:

- Ensure other facilities adapt the strategies of the teaching hospitals by providing awareness in the facilities they work in the absence of lack of funds for outreach programmes.
- Collaborate with the GHS to train managers of mental health units on recording of mental health awareness creation activities to inform subsequent programmes.

3.3.1 Non-availability of Psychotropic medicines in hospitals is hampering the treatment of mental health patients.

7. The mental health units of the various facilities visited did not receive medicines as required for the treatment of mental health cases within the period under review.

8. The Central Medical Stores (CMS) was unable to supply the quantities of psychotropic drugs requested by the three main psychiatric hospitals. We tested the availability of a sample of the commonly used drugs at the three psychiatric hospitals and found that the Central Medical Stores was unable to meet the requirements of the hospitals in each of the four years of the audit period. The Central Medical Stores' best success rate in meeting demand was 50% in 2018 for Pantang Hospital. The shortage has compelled community psychiatry nurses at the municipal and district hospitals to prescribe medicines to patients to buy on the open market for use at their own cost as these medicines did not match the ones prescribed by mental health officers. Also, any drug not supplied by the Central Medical Stores and is procured by the health facilities without being an NHIS drug is sold at mark-up to patients.

9. We recommended that, the MHA should:

- Collaborate with the Central Medical Stores in the distribution of psychotropic medications by considering the patient turn out at treatment facilities to ensure that burdened (high patient visit) facilities are apportioned adequate medications for treatment of patients.
- Collaborate with the Ministries of Finance and Health to enhance the procurement process for the acquisition of psychotropic medicines for treatment of patients.

3.3.2 MHA is not monitoring alternative mental health treatment by Traditional and Faith-Based Healers

10. Traditional and Faith Based Healers (TFBH) provide alternative treatment for mental health cases to the orthodox means as carried out by the mental health units at health facilities. The district community psychiatry nurses do not regularly visit healing centres to monitor their operations. They cited the lack of

resources (motor bicycles and fuel) to aid in monitoring the activities of the Traditional and Faith Healing Centres. Also, the Authority had not conducted any training for TFBHs during the audit period 2016-2021. However, sampled regional mental health coordinators (Bono, Ashanti, and Volta regions) collaborated with mental health stakeholders (eg. Basic Needs, Humans Rights Advocacy Centre) to conduct training on mental health in 2019 for the TFBHs. Participants were trained on the rights of patients with mental illness, the importance of encouraging clients to be part of self-help groups as well as protection of the human rights of patients. The audit revealed that some TFBH centres chained some of their patients as they administer treatment to the patients. An example was Aposs Prayer Camp in Kibi where patients (aggressive ones) were chained by managers of the facility.

11. We recommended that, the MHA should:

- ensure that district mental health officers regularly visit the TFBH centres to ensure TFBH centres abide by the guidelines on the treatment of mental health patients including their human rights.
- assist district mental health officers to design training programmes for TFBHs aimed at informing them on emerging issues regarding mental health care management. Also, the training programmes should be carried out regularly, recorded and evaluated to know its impact on their operations.

3.3.3 Few professionals for mental health care service delivery

12. Currently, Ghana had 40 psychiatrists at the time of the audit. The psychiatrists to patient ratio was 1:750,000 compared with the standard of 1:100,000 proposed by the World Health Organisation for the African region1. This means Ghana's current population of 30 million should have a minimum of 320 psychiatrists. The total number of psychiatrists that the three main psychiatric treatment facilities are required to have at the time of the audit were 22 but, the psychiatric treatment facilities had a total of nine (9) at post. All the psychiatrists are distributed among the three main mental health facilities and the teaching hospitals nationwide.

13. Again, 17 out of the 26 Psychiatrist available to MHA are in the Greater Accra and five in Ashanti Regions. We found the distribution skewed in favor of the two main cities because of lack of incentives and good working conditions available in the other regions and districts. The three main mental health treatment facilities and teaching hospitals carry out training programmes for mental health professionals to improve service delivery. Also, the MHA in 2016 put in place the Professor Adgyakum's Annual Medical Students Debate on mental health amongst the Medical Schools to help build the interest of medical students in the field of mental health as a long-term plan of increasing the number of psychiatrist professionals.

14. The Koforidua Regional Hospital in collaboration with the Regional Coordinator for mental health organised on weekly basis a 'Clinico Pathological Meeting' where a psychiatrist is invited for consultation for all mental health cases in the region. According to the officials, the arrangement is to create an avenue for mental health patients in the region to have a professional touch of a psychiatrist during treatment.

15. We recommended that, the MHA;

- provide incentives to attract professionals to the mental healthcare environment.
- develop a policy on training of mental health staff in psychiatric treatment facilities to improve on service delivery.
- adopt the strategy used by the Koforidua Regional Hospital and the Regional Mental Health Coordinator on the "Clinico Pathological Meeting" in the absence of mental health professionals in the regional and district hospitals to ensure more mental health patients experience some professional contact during treatment.

3.4 The Mental Health Fund is not delivering its intended purpose

16. Treatment activities of the three main psychiatric treatment hospitals are to be funded from government subventions and from the Mental Health Fund. However, government subventions during the audit period were not released in the amounts for operational activities to the MHA as required. Also, the Mental

Health Fund as a complementary funding to that of government launched in 2018 to fund some specific activities of the MHA was not active as at the time of the audit. The amount realized from the launch was GH¢10,000. The Fund had an initial inflow of GH¢89,008.00 in 2015. We found that the monies were not used for the purposes stated in the Act as at the time of the audit, the fund had a closing balance of GH¢8,884.58. The funds were used for printing and sensitization instead of skills training and others.

17. The Authority expended about 93.2% of the total fund inflow on printing and for workshops which were contrary to the key activities to be carried out using the fund as specified in the Section 81 (2) (a-d) of Act 846. Our analysis also shows that 71% of the expenditure was used to print of Calendars. Donations into the fund had halted for the last five years which made the Authority push for the approval of a mental health levy as specified in Section 59 (4) of (L.I. 2385) to provide adequate funds to support its operational responsibilities. However, as at the time of the audit, the levy had not yet been approved. Releases from Ministry of Finance for goods and services were inadequate which hampered the operations of the facilities in providing critical service to clients.

18. We recommended that, the MHA should:

- plan their activities and identify donors and corporate bodies that will be willing to support those activities, negotiate with them for support.
- impress on Parliament to consider the case of the Mental Healthcare levy for implementation to address the financial challenges of the MHA, and
- draw programmes to repatriate treated and sound patients to join their families for reintegration with the aim of reducing the cost of care on paupers/vagrants.

CHAPTER ONE

Reasons for the audit

19. Mental health care is services devoted to the treatment of mental illnesses and improvement of mental health in people with mental disorders or problems[2]. Mental health care in the country has traditionally been hospital-based where patients spend months and years on admission. Psychiatric treatment relies exclusively on doctors and nurses while other core mental health services like clinical psychological services and occupational therapy are absent.

20. Mental health services in Ghana are available at various levels of care provided through specialized psychiatric hospitals (Accra, Pantang and Ankaful) close to the capital and accessible to a limited number of the population. The Mental Health Authority is responsible directly for mental health care in the three main Psychiatric Hospitals and indirectly through collaboration with other sister health service providers such as Ghana Health Service, Christian Health Association of Ghana, and the Teaching Hospitals. The prevalence of mental health disorders in Ghana is 13 % of the adult population[3]. The disorders are of varying forms (anxiety disorders, dementia, schizophrenia, depression, psychotic disorders, post-traumatic stress disorder and among others) and require care which could be either pharmacological or non-pharmacological[4].

21. The Key Fact report of the World Health Organisation (WHO), 2019 states that out of the 30.4 million population of Ghana, 650,000 are suffering from severe mental disorders and a further 2.2 million, are suffering from a moderate to mild mental disorders. The treatment gap is 98% of the total population expected to have a mental disorder. This means that the treatment of mentally ill patients in Ghana is low. For example, a survey conducted in 2012 by Mark Roberts et al on Ghana's mental health system showed that there were an

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[2] https://www.collinsdictionary.com
[3] World Health Organization. WHO-AIMS report on mental health system in Ghana 2011
[4] Patel V, Araya R, Bolton P. Treating depression in the developing world. Trop Med Int Health. 2004;9(5):539–4

estimated 2.4 million people with mental health problems of which 67,780 (i.e., 2.8%) received treatment in 2011.

22. The mental health service in Ghana is facing many challenges. The stigma attached to the psychiatric profession deters people from joining it. The few health personnel to have been fully trained, particularly the nurses, often emigrate. Most of the wards are overcrowded with patients who are not accepted at home. Ghana has 37 psychiatrists for a population of 30 million, which indicates a huge treatment gap for patients who need professional psychiatric attention. Since psychiatric services are free and the hospital facilities depend on government funding (which is insufficient) and do not generate funds, they are always under-resourced. The funding for mental health was 3.12% of the total mental health budget for 2019. A large proportion of this goes into staff costs, drugs and feeding of patients.

23. Parliament in March 2012 passed the Mental Health Act 2012 (Act 846), which established a Mental Health Authority to propose, promote and implement mental health policies and provide culturally appropriate, humane, and integrated mental health care throughout Ghana. Since the coming into effect of the Act, the number of people seeking treatment has increased, but the challenges mentioned above persist.

24. To assess how mental health delivery in the country is managed in the light of the challenges, the Auditor-General in line with Section 13(e) of Audit Service Act, 2000 (Act 584), commissioned a Performance Audit into Mental Health Care Delivery in Ghana.

1.1 Purpose and Scope of the audit

25. The purpose of the audit was to determine whether Mental Health Authority (MHA) is ensuring that patients who need mental health care get the required treatment. The audit was carried out at the MHA, selected teaching, regional and district hospitals. The period of study was from 2016 to 2020. The audit focused on awareness creation of the public on care and treatment of mentally ill patients in Ghana, monitoring of mental health activities by the MHA and the operation of the mental health fund.

1.2 Audit Objective

26. The objectives of the audit were to determine whether:

- the Mental Health Authority planned and carried out awareness creation on mental health care and treatment in Ghana.
- MHA is providing treatment for mentally ill patients as required.
- MHA monitored treatment centres to ensure patients who suffer from mental disorders were effectively treated and
- the Mental Health Fund meets its object of providing financial resources to enhance mental health care.

1.3 Audit Questions and Assessment Criteria

27. The audit questions, assessment criteria and sources used to assess the performance of the MHA on the management of mental health care delivery in Ghana is attached as ***Appendix 'A'***.

Audit Methodology

28. We carried out the audit by reviewing documents, interviews, and observations at mental health treatment facilities. We sampled treatment facilities from three psychiatric hospitals in Ghana, four teaching hospitals, five regional hospitals and 15 district hospitals as well as forty selected traditional and faith-based healers. At the sampled facilities and at MHA we reviewed the document listed in ***Appendix 'B'*** for information on the mandate, vision, mission, and objectives in the provision of mental health care delivery. We also reviewed the mental health policy that guides the operations and functions of the Mental Health Authority and general operations and activities in the mental health care system in Ghana. We interviewed officers listed in ***Appendix 'C'*** to gain insights and explanations to problems we identified during the audit. We visited wards and out-patient departments of the sampled facilities as well as the faith-based facilities to observe the processes patients are taken through and environmental conditions they are treated whilst accessing mental health care.

CHAPTER TWO

MENTAL HEALTH CARE DELIVERY IN GHANA

2.0 Background of the audit

29. According to the World Health Organisation (WHO), positive mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to his or her community. Mental Health care delivery in Ghana is provided by both government and private institutions. The Ministry of Health has oversight responsibility over the whole system of Mental health delivery including policy formulation, monitoring, and evaluation. Under the public health system, mental service delivery is undertaken by Mental Health Authority, Ghana Health Service, Christian Health Association of Ghana (CHAG), the Teaching hospitals and Quasi-government health institutions.

30. Mental health care in the country is delivered in selected district health facilities providing care at various levels including CHAG hospitals that supplement in the provision of mental health care where the district does not have hospital. The facilities are three specialised psychiatric hospitals, (Accra Psychiatric, Pantang and Ankaful hospitals) all located in the southern sector of the country, ten regional hospitals, five teaching hospitals and 260 district hospitals. The three main psychiatric treatment hospitals, the mental health wings of the teaching and regional hospitals provide specialised care services to the public whereas the district mental health hospitals and Community Health Planning Service (CHPS) compounds provide community-based care. Regional and district mental health hospitals refer patients to the three main psychiatric and teaching hospitals when cases go beyond their capabilities. The traditional and faith-based healers also support the treatment of mentally ill patients but there are challenges (non-availability of psychotropic medications and limited clinicians) in their operations as they operate informally and largely do not document their activities.

31. In Ghana, most psychiatric care is attended to by mental health nurses, Community Mental Health Officers (CMHOs), and Clinical Psychiatric Officers with very little supervision by psychiatrists (Agyapong VIO, Farren C & McAuliffe E. 2016). Involvement of the private sector is limited to a few private psychiatrists

and non-governmental organizations providing clinical and community services, respectively. Majority of mental health care is provided through specialized psychiatric hospitals. Mental health services provided include awareness creation, case management/treatment and rehabilitation of treated patients.

32. In 2012, Parliament passed the Mental Health Act, 2012 (Act 846) which sought to improve the system of mental healthcare in Ghana. The Act includes provisions for the creation of a modern, community-based mental health system and for the protection of the rights of persons with mental disorders. The Mental Health Authority was established to oversee the implementation of, and ensure compliance with, quality mental healthcare. To ensure sustainability of the mental health system, World Health Organisation in 2013, approved a "Comprehensive Mental Health Action Plan for 2013-2020" for Member States as a form of commitment to take specific actions to improve mental health and to contribute to the attainment of a set of global targets. The overall goal was to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights, and reduce the mortality, morbidity, and disability for persons with mental disorders.

2.1 Legal Mandate

33. The Mental Health Authority (MHA) was established by an Act of Parliament, Mental Health Act, 2012 (Act 846), to propose, promote and implement mental health policies and provide culturally appropriate, humane, and integrated mental health care throughout Ghana. The Mental Health Regulations, 2019 (L.I. 2385) spells out the functions of the various divisions of the MHA.

2.2 Vision of MHA

34. To ensure quality mental health care for all persons commensurate with Ghana's middle-income status.

2.3 Mission of MHA

35. To promote mental health, prevent mental illness and provide accessible, community-oriented, integrated, quality and culturally appropriate mental health care to persons with mental illness.

2.4 Objectives of Mental Health Authority

36. The objectives of the Authority that are linked with the audit objectives are to:

- Propose mental health policies and ensure their implementation.
- Promote mental health and provide humane care including treatment and rehabilitation in a least restrictive environment; and
- Promote a culturally appropriate, affordable, accessible, equitably distributed, integrated and specialized mental health care that will involve both the public and the private sectors.

2.5 Functions of the MHA

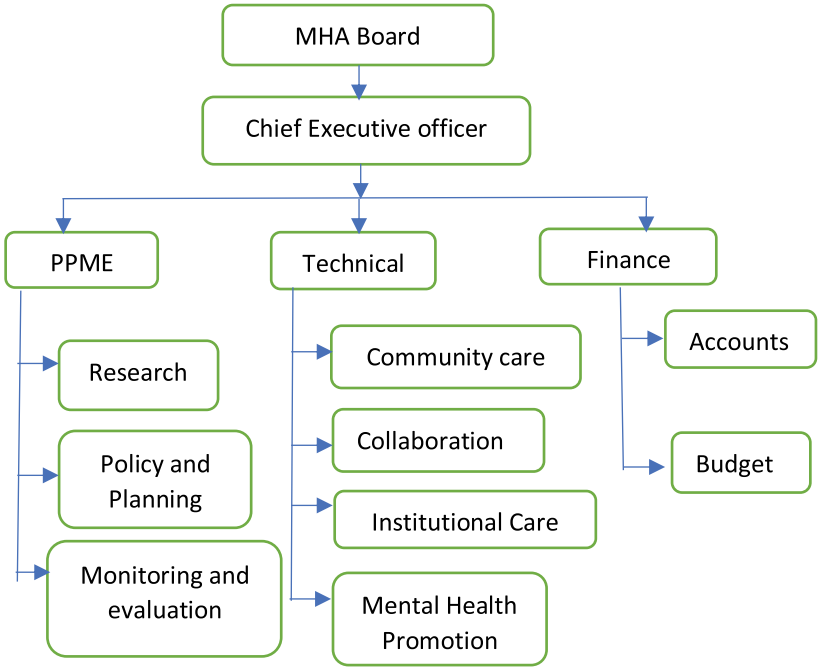
37. To achieve the set objective, the Mental Health Authority is to:

- Provide a mental health service that shall collaborate with the general health care system at the primary, district, regional and national levels, and specialized services, as necessary.
- Collaborate with other healthcare service providers to ensure the best care of persons with mental disorder.
- Ensure and guarantee the fundamental human rights of persons with mental disorder against discrimination and stigmatisation.
- Provide psychiatric in-patient care which is of an equitable standard to physical in-patient care.
- Collaborate with the Traditional and Alternative Medicine Council and other providers of unorthodox mental health care to ensure the best interest of persons with mental disorder.

2.6 Organisational Structure

38. MHA is headed by the Chief Executive Officer (CEO). The Authority has six main divisions that helps in carrying out its activities. The divisions are Administration, Technical, Pharmacy, Finance, Rights and Quality, Policy, Planning Monitoring and Evaluation (PPME) and the Internal Audit. The three major divisions that are directly involved in MHA's activities in managing the overall promotion and treatment of mental ill patients in Ghana are the Technical, PPME and Finances divisions. See ***Appendix 'D'*** for a detailed organisational structure of MHA. The authority's structure in relation to mental health care delivery is depicted in *Figure 1*.

Figure 1: Accountability structure on mental health delivery



2.6.1 Technical Division

39. This division is headed by a director. The technical care division has four main departments. These are the Institutional Care, Community Care, Collaboration and Mental Health promotion departments. The department is responsible for the preparation and publication of quarterly reports on technical issues pertaining to the authority and advise the chief executive on technical matters.

2.6.2 Policy planning, monitoring, and evaluation division.

40. This division is headed by a director and comprises of four main departments: Policy Planning, Monitoring and Evaluation, Research, and ICT departments. The division is responsible for the implementation of:

- policies, strategic plans,
- advising the CEO on issues relating to policy and planning activities of the authority,
- reporting to the CEO on the outcome of research activities,
- periodic visits to the regions to evaluate, and
- monitor the activities of the authority.

2.6.3 Finance

41. The Finance division is headed by a director and comprises two units namely, Accounts and Budget units. The division is responsible for the management of the finances of the Authority and advising the Chief Executive on the financial status of the Authority. The Director is also responsible for the preparation and publication of reports on the financial status of the Authority.

2.7 Funding

42. The funds used for the operations of the Mental Health Authority as provided in Section 89 of the Mental Health Act, 2012 (Act 846) are:

- Monies approved by Parliament.
- Monies derived from fees.
- Donations, grants, and gifts.
- Moneys derived from investments and
- Any other moneys that are approved by the Minister responsible for finance.

43. Table 1 shows monies approved and released to MHA for the period 2016-2019.

Table1: Budgeted and actual funds released for mental care delivery for the period 2016-2019

Year	Budgeted GH¢	Actual GH¢	Variance GH¢	% Percentage received
2016	246,836,978.47	38,432,116.52	(208,404,861.95)	15.57
2017	215,275,576.40	59,763,113.24	(155,512,463.16)	28.0
2018	235,873,713.60	50,988,832.86	(184,884,880.74)	22.0
2019	212,034,301.00	57,077,832.12	(154,956,468.88)	27.0
Total	**910,020,569.47**	**206,261,894.74**	**(703,758,674.73)**	23

Source: Annual reports of the MHA (2016-2019)

44. For the period under review, the Mental Health Authority budgeted for a total of GH¢910,020,569.47 and received GH¢206,261,894.74 as funds to support its operations. This represents 22.67% of the budgeted funds for the period under review. The 2017 actual releases increased by 64.3 % from that of 2016. The 2018 financial year recorded a reduction of 14.70% in budgetary support for operational activities within the period whereas 2019 had an increase of 10.67%.

2.8 Key Players and their Responsibilities

45. The key players in the delivery of mental health care and their roles are shown in Table 2.

Table 2: Key players and their roles in mental health care delivery

Key players	Roles
Chief Executive Officer (MHA)	Responsible for the day-to-day administration of the authority by ensuring provision of quality mental health care services
Technical Division (MHA)	Provide technical support in carrying out educational promotion and treatment of mentally ill patients. The division is in-charge of the psychiatric hospitals and monitor the operations of the Traditional and Faith-Based Healers.
Policy Planning Monitoring and Evaluation Division (PPME, MHA)	Undertake periodic visits to the regions to evaluate and monitor the activities of the authority in

Key players	Roles
	respect to promotion and treatment of mentally ill patients and other activities of the authority
Finance Division (MHA)	Provide budget to support promotion and treatment of mentally ill patients.
Institutional Care Department (ICD, MHA))	Monitor and supervise the activities of the various treatment facilities with regards to promotion and treatment of mental ill patients
Mental Health Promotion Unit (MHA)	Responsible for the implementation of promotional activities in all care facilities
Community Care Division (MHA)	In charge of the treatment facilities at the community level and responsible for ensuring promotional activities on mental health are carried out
Pharmacy Unit (MHA)	Compile the list of drugs required from the mental health facilities for the treatment of mentally ill patients
Psychiatric Hospitals	Provide specialised treatment for mentally ill patients in the country
Teaching Hospitals	Provide tertiary treatment and referral care for mental health patients.
District Psychiatric Units	Serve as the first point of call for mental health patients in their quest for mental health care services in the districts.
Regional Mental Health Coordinators (RMHC)	Responsible for the execution of policies and coordination of mental health activities at the regional level
District Mental Health Coordinators (DMHC)	Responsible for the execution of policies and coordination of mental health activities at the district level
Traditional and Faith Based Healers	Traditional healers are the main non-orthodox in the field of mental health that provide care to the mental inpatients

Source: Field work (November-December 2020)

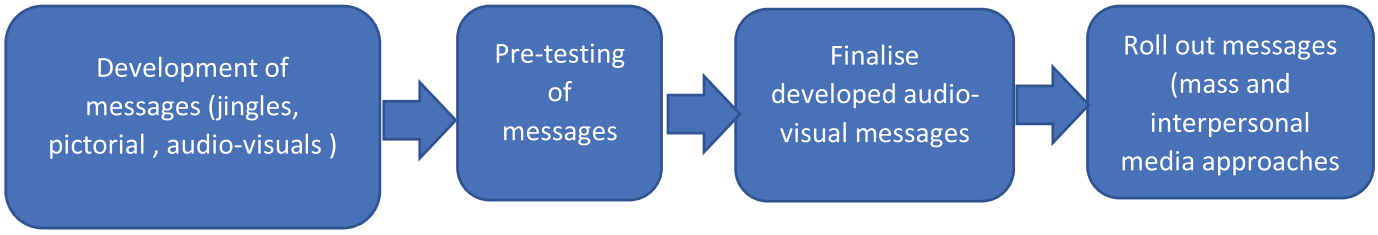
2.9 PROCESS DESCRIPTION ON MENTAL HEALTH CARE

46. The processes mental health care delivery is carried out in Ghana include the promotion of mental health, treatment and or rehabilitation/reintegration. Details of the processes are described in Figures 2-4.

2.9.1 Mental health promotion/prevention

47. The Mental Health Promotion Unit provides information on mental health to the public to create awareness with the objective to reduce stigma and discrimination of mentally disturbed people in the population. The process of mental health awareness creation is depicted in *Figure 2*.

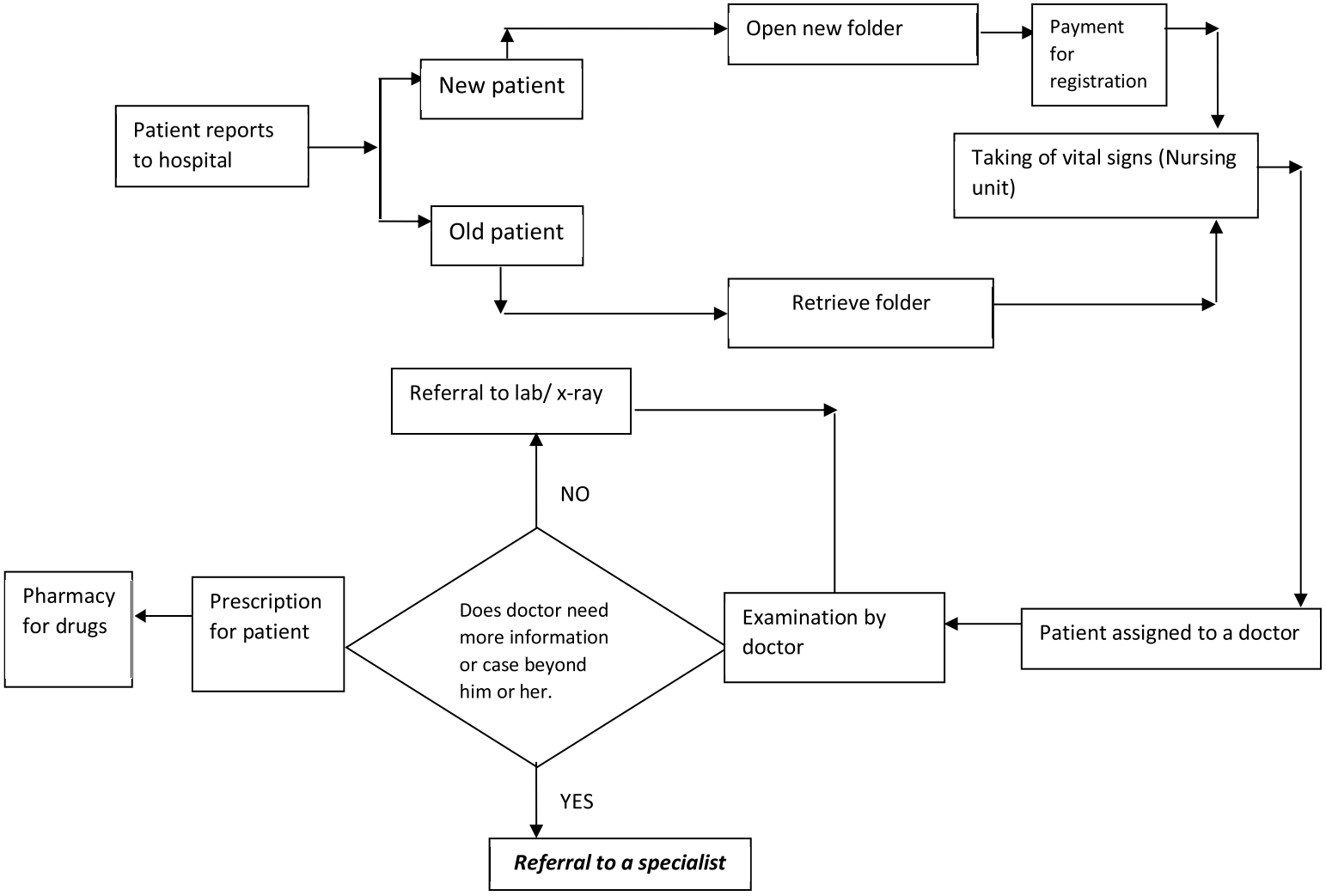
Figure 2: Mental health awareness creation



2.9.2 Case Management/Treatment

48. The treatment of mental patients is integrated into the general health care system. Mentally disturbed patients enter any of the District, Regional, Teaching Hospitals or the three main psychiatric hospitals in Ghana to receive treatment. The treatment process is depicted in Figure 3.

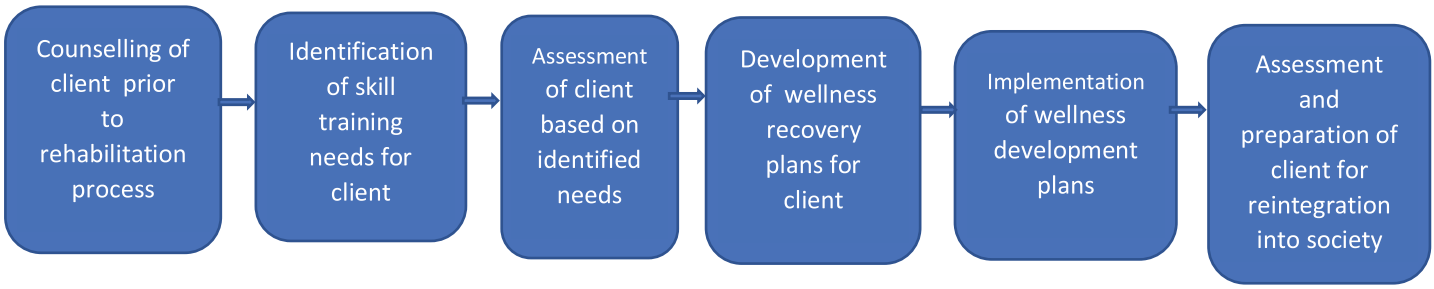
Figure 3: Treatment process for mental patients



2.9.3 Rehabilitation/Reintegration

49. Rehabilitation/ reintegration of treated mentally ill patients into society is an integral part of the mental health care delivery process in Ghana. At the end of treatment, a patient is either discharged, or goes through a rehabilitation/reintegration process. The process of rehabilitation/reintegration is described in *Figure 4*. Details of the systems description in mental health care delivery is provided in ***Appendix 'E'***.

Figure 4: Rehabilitation/reintegration of mental health patient



CHAPTER THREE

3.0 FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

3.1 Introduction

50. The audit sought to find out the extent to which the Mental Health Authority have developed programmes, activities, and strategies to improve mental health care delivery taking into consideration awareness creation of the public on the need to adopt preventive measures and treatment for mentally ill patients in Ghana. Although the MHA has put in place programmes (durbars, outreaches, home visits among others) and activities to aid the delivery of mental health care service in the country, mental health care in Ghana has been fraught with several challenges leading to depreciation in care. These are:

A. Awareness creation on mental health care delivery

i. MHA did not effectively plan for awareness creation.

ii. Non-execution of mental health awareness creation plans by MHA.

B. Treatment of mental health patients

i. Non-availability of psychotropic medications hampering the treatment of mental health patients.

ii. Alternative mental health treatment by Traditional and Faith-Based Healers.

iii. Inadequate professionals for mental health care service delivery.

iv. The Mental Health Fund is not delivering its intended purpose.

3.2 Awareness creation on mental health care delivery

51. Section 2(c) of the Mental Health Act, 2012 (Act 846) puts a responsibility on the Mental Health Authority to promote mental health and provide humane care including treatment and rehabilitation in a least restrictive environment. For MHA to ensure a reduction in the prevalence of mentally ill patients on the streets, we expect the MHA to educate the public to reduce the causes of mental

illness. To achieve this, we expect the MHA to have planned and budgeted for awareness creation programmes it carried out in the period under review.

3.2.1 MHA did not plan adequately for awareness creation activities

52. The Community Care Department (CCD) of the MHA as at the time of the audit was responsible for carrying out awareness creation on mental health care delivery in the country. Currently, an awareness creation unit has been established by the MHA which is responsible for awareness creation on mental health. The department planned and budgeted to create awareness on mental health issues during the period under review. According to the Deputy Director for Community Care, the activities in the 2016 plans were repeated for the years 2017 to 2019 due to non-availability of resources for execution of the plan in each of the years. The CCD planned to establish Community Mental Care and Psychiatric wings at the regional hospitals, engage in "support supervision" and performance review, community mental health activities, celebration of days related to mental care, among others.

53. We noted that the plans were not based on any data of major causes of mental health to enable effective messaging and targeting of awareness dissemination. The plans did not indicate the locations many of the activities were going to be executed, the details (content) of activities to be carried out to address thematic areas and targets to enhance assessment of activities carried out. We also noted that, the awareness creation plans by the CCD did not address the categories of mental health illness to enhance the assessment of the impact of its awareness creation programmes.

54. Accra Psychiatric, Pantang and Ankaful hospitals carried out awareness creation programmes on mental health issues through their Community Psychiatry Units. The community psychiatry units prepared plans for weekly home visits, daily talks at the Outpatient Department (OPD), school health talks and community durbars, among others. These were to get the public informed about mental health issues and their effects on human lives and productivity. The plans were approved by the hospital directors prior to their execution. The plans for Pantang and Ankaful hospitals were with budgets. The plans contained the activities to be carried out, their locations, outcomes, and the time frame but did not contain targets (the extent to which the causes to mental health issues are addressed), responsibilities, and roles.

55. The three main treatment facilities (Accra Psychiatric, Ankaful and Pantang Hospitals) did not make annual projections on targeted mental health education programmes to address the causes of mental health challenges (drug abuse, long term stress, long term physical condition, neglect, feelings of loneliness or isolation among others).

56. We noted that, the content of awareness creation programmes by the treatment facilities did not have inputs from the MHA as the mother body responsible for mental health awareness creation nationwide. According to the Acting Director for Administration, the programmes approved by the MHA for the Psychiatric hospitals affirms the involvement of their inputs for programmes to be executed.

57. With regards to awareness creation, the teaching hospitals on the other hand, had community psychiatry units responsible for awareness creation in their operational jurisdiction. Though the hospitals planned for awareness creation activities, there were targets to be met within the period under review. The teaching hospitals did not budget for awareness creation programmes. We noted from interviews with officials of the mental health wings of the hospitals that, awareness creation was usually carried out at the various clinics in the hospitals as a routine activity in the teaching hospitals hence, the non-preparation of budgets.

58. Mental health care services are also carried out by Ghana Health Service (GHS) in the Regional, Municipal and District Hospitals. The facilities have mental health units responsible for planning and budgeting for mental health awareness creation programmes. The units had programmes of work which showed the activities to be carried out, dates for the execution and locations the activities were to take place. Though the programmes were carried out, the plans had no targets on what was to be achieved, the resources needed to carry out the activities, the targeted population and the expected impact of activities when implemented.

59. Heads of the psychiatry units in the municipal and district hospitals stated that, they had always planned their awareness creation programmes without the indicators pointed out by the audit team as well as corresponding budgets.

According to the heads, they had not been trained on how to prepare comprehensive plans to include the indicators. According to the heads of the psychiatry units, the heads of the treatment facilities had consistently failed to support the units with resources for awareness creation activities. According to the unit heads, staff have personally funded awareness creation activities carried out on an ad hoc basis.

Conclusion

60. The MHA and the psychiatric treatment facilities although planned for awareness creation, the plans were not comprehensive and lacked indicators to help assess the performance of the plans. Thus, the awareness creation plans were not informed by proper gathering of information to identify what type of message should be contained in the jingles, or how, in what form and where it is to be delivered taking into consideration the target population.

Recommendation

61. We recommended that MHA should:

- Ensure that, awareness creation plans by psychiatric treatment facilities is comprehensive to include the type of message, the means of carrying out the message, the form it is to take and where it should be delivered in addition to responsibility roles for implementation.
- Ensure that, psychiatric professionals at all levels of care are trained on how to develop detailed plans and budgets to ensure effective awareness creation on mental health.

Management Response

62. According to management, mental health awareness creation activities was to be undertaken by the Mental Health Promotion Unit which was not established during the period under review which necessitated the Community Care Department to include the awareness creation role to its core functions. Management further stated that, the awareness creation activities planned and executed might not have been satisfactory to the audit team's expectation due to inadequate funding of the Authority.

63. Management was of the view that mental health awareness creation cuts across the Teaching Hospitals, District and Regional/ psychiatry units of Ghana Health service facilities hence the responsibilities fall under their respective agencies. In this regard management mentioned that the Community Care Department of the Mental Health Authority provides supportive visits and coordination as and when necessary.

3.2.2 Non-execution of mental health awareness creation plans by MHA

64. Section 14(2)(a)(b) &(f) of the Mental Health Regulations, 2019 (L.I. 2385) requires the MHA to employ and apply arts and media facilities for public education on mental health and engage the services of mental health counsellors for the promotion of mental health. The Section entreats the Authority to support mental health service users, carers, and self-help support groups with appropriate information for community education and sensitisation on mental health. Section 14(3)(a) &(b) allows the Authority to use the print and electronic media including films, leaflets, pamphlets, posters, and signage to educate the public on mental health.

65. The Community Care Department (CCD) of the MHA planned to inform the public on mental health through community durbars, health walks, radio talks, visits to schools, churches and mosques, among others. The CCD could not carry out the activities it planned in each of the four years. However, the Authority was able to occasionally lobby for slots from the electronic media for awareness creation on annual international day celebrations such as world suicide day and world epilepsy day.

66. The three psychiatric treatment facilities wrote to churches, schools and media houses notifying them on their intention to undertake mental health awareness creation. However, there was no evidence on the actual activities being carried out on mental health awareness creation. We noted through interviews with the community psychiatry nurses that, they carried out health talks at institutions, on radio and health walks through selected streets in the jurisdictions of the facilities, sharing leaflets (handbill with information on mental health) but did not record the activities carried out. According to the psychiatry nurses interviewed, the exercises were to get the general public informed on how to handle family and community members suffering from mental illness with care to help improve their conditions socially.

67. Staff of community psychiatry units at the selected teaching hospitals usually visited clinics within the hospitals and communities in the jurisdiction of the hospitals to educate them on mental health care but did not record those activities. According to the mental health officers, as at the time of the audit, awareness creation in their facilities of operation is a routine activity hence, their failure to report as such. Community psychiatry officers, staff and mental health nurses were the ones who carried out awareness creation in the facilities during the period under review. For example, at Korle-Bu Teaching Hospital, psychiatrists, psychologists, and mental health prescribers organised daily mental health talks at the various clinics and periodic mental health outreach programmes in surrounding communities. This according to the officers helped the general public within the jurisdiction of the facility to be informed about the general causes of mental health illness and the need to adapt to preventive lifestyles to avoid being victims.

68. Our sampled regional and district health facilities carried out awareness creation at schools, churches, and the communities in which the health facilities are located. The activities carried out included radio and community health talks on mental health, routine and special home visits of clients, and case search for clients (community psychiatry staff moving into communities to look-out for mental health patients who have not received mental health care). In other instances, the mental health units at the selected facilities engaged members of the communities through durbars to talk about mental health issues but did not record them. However, our interactions with about 100 randomly selected community members in the selected districts indicated that health officers occasionally talked to them about mental health issues regarding how they are to handle persons with mental health challenges to improve their conditions in the process of accessing treatment.

69. According to the heads of the psychiatry units, they visited the homes of patients as part of the effort to convey mental health information to inform community members on mental health issues and to assess the conditions of patients. Community mental health officers, community psychiatry nurses, staff and rotation nurses participated in awareness creation both in the facilities and in adjourning communities. Also, selected regional mental health coordinators carried out mental health awareness creation activities in their jurisdictions of

operation. We noted that, the regional mental health coordinators liaised with Non-Governmental Organisations and stakeholder institutions to carry out awareness creations programmes to get the general public informed on mental health issues.

70. The inability of the MHA to execute its activities for awareness creation denied many people from gaining information on the causes of mental health illness and its effects on their lives and economic activities.

Conclusion

71. The MHA did not carry out awareness creation activities effectively as planned. However, the psychiatric treatment facilities executed awareness creation activities but failed to record the activities to inform decisions on ensuing programmes.

Recommendations

72. We recommended that the CCD of MHA should:

- Ensure other facilities (regional and district hospitals) adapt the strategies of the teaching hospitals by providing awareness in the facilities they work in the absence of lack of funds for outreach programmes.
- Collaborate with the GHS to train managers of mental health units on recording of mental health awareness creation activities to inform subsequent programmes.

Management Response

73. Management commented that the planned and executed mental health awareness creation activities undertaken may not have been satisfactory due to inadequate fund of the Authority's activities.

3.3 Treatment of mental health patients

3.3.1 Inadequacy and erratic supply of Psychotropic medicines in hospitals is hampering the treatment of mental health patients

74. Section 57 (4) of the Mental Health Act, 2012 (Act 846) requires that every person with mental disorder to have access to psychotropic drugs (drugs for treatment of mental illness) as well as any other psychosocial rehabilitative care where necessary. We expected the MHA to make available psychotropic medicines at all levels of treatment for mental health patients to improve treatment conditions.

75. Psychotropic treatment medicines form an integral component in the treatment of persons with mental disorders. Some of the popularly used medicines in Ghana are Olanzapine and Chlorpromazine injection, etc. The medicines are to be made available by the MHA through the Central Medical Stores to mental health treatment facilities nationwide at no cost to the mental patient. However, these medicines were not available when needed by mental health treatment facilities for the treatment of patients.

76. The Pharmacy unit at the MHA which is responsible for medicines for mental health care received requisitions for psychotropic drugs from the three main psychiatric treatment facilities and the regional medical stores in Ghana. The regional medical stores were responsible for the supply of medicines to the district mental health facilities. Mental health units at the sampled health facilities other than the three main psychiatric hospitals had challenges with availability of psychotropic medicines. The mental health units did not receive medicines as required for the treatment of mental health cases within the period under review.

77. We found that the Central Medical Stores (CMS) was unable to supply the quantities of psychotropic drugs requested by the three main psychiatric hospitals. We tested the availability of a sample of the commonly used drugs at the three psychiatric hospitals and found that the Central Medical Stores was unable to meet the requirements of the hospitals in each of the four years of the audit period. Table 3 shows the quantities of psychotropic medicine requested by the three psychiatric hospitals and the actual quantities the Central Medical

Stores could supply. The Central Medical Stores' best success rate in meeting demand was 50% in 2018 for Pantang Hospital.

Table 3: Psychotropic medications requested by the three Psychiatric hospitals and quantities supplied by the Central Medical Stores for the period 2016-2019

Year	Accra Psychiatric Hospital		Pantang Hospital		Ankaful Hospital	
	Quantity of Psychotropic medications requested	Quantity of Psychotropic medications Supplied	Quantity of Psychotropic medications requested	Quantity of Psychotropic medications Supplied	Quantity of Psychotropic medications requested	Quantity of Psychotropic medications Supplied
2016	46	0	36	6	-	8
2017	54	9	37	-	-	1
2018	46	11	32	16	-	12
2019	40	14	40	-	39	12

Source: Audit teams' analysis of data on psychotropic medications from the three treatment facilities (November -December 2020)

78. From table 3, the kind of medicines requested by the psychiatry treatment facilities is depended on the drug needs assessment carried out by the treatment facilities. Ankaful hospital could not provide the audit team with quantity requested for the period from 2016-2018. According to the head of the Pharmacy unit, he could not trace the requisitions for that period because the unit was relocated to a new site which resulted in loss of the requisitions books due to the movement of documents. He also mentioned that he was not at post for the said period hence, his inability to locate the requisition books to submit for examination.

79. Our interactions with heads of the three main treatment facilities and heads of sampled mental health units on the supply of medications indicated that, the drug requests submitted to the Central Medical Stores through the MHA were sent late (for about nine months or more). According to the Deputy Director for Pharmacy Services (DDPS), late supply of medications was a result of non-availability of funds coupled with the long procurement process for psychotropic drugs for onward distribution to treatment facilities. This according to the DDPS resulted in shortages which in the long run affected the treatment process and conditions of patients.

80. The shortage of psychotropic medicines at psychiatric treatment facilities compelled community psychiatry nurses at the municipal and district hospitals to prescribe medicines to patients to buy on the open market for use. Selected care givers (60) the audit team interacted with at the selected locations indicated that, although mental health care is free, medicines were prescribed for them to buy at their own cost. The CEO of the Mental Health Authority explained that, mental health care is supposed to be free as per the Mental Health Act 2012, Act 846 but patients and care givers are made to purchase prescribed drugs for treatment from outside the facilities. The CEO stated that, medicine is critical in treating mental health cases but the supply from government is woefully inadequate hence, this strategy by treatment facilities to improve the treatment process.

81. During the audit, we found that due to delay in supply of psychotropic medicines, MHA adopted a system where private pharmaceutical companies were invited to sell psychotropic drugs to patients with a mark-up aimed at reducing the erratic supply of medicines by the Central Medical Stores. This system has also been adopted by the three psychiatric hospitals to ease access to psychotropic medicines.

82. The three main psychiatric hospitals as a result of the erratic supply of psychotropic drugs from the Central Medical Stores for the period under review committed part of their drug funds to procure psychotropic drugs for sale to mental patients. According to the Hospital Directors, the drug fund is a pool of funds committed to the payment of drugs served under the National Health Insurance Scheme (NHIS). In this regard, any drug not supplied by the Central Medical Stores and is procured by the facilities from the fund without being an NHIS drug is sold at mark-up and proceeds redeposited into the drug fund to serve its purpose.

83. The non-availability of psychotropic medicines at the mental health treatment facilities resulted in patients purchasing medicines from the open market as these medicines did not match the ones prescribed by mental health officers.

Conclusion

84. The Non-availability funds delayed the procurement process for psychotropic medicines which contributed to the inadequacy and erratic supply of the medicines at the time they were needed for treatment of mental health patients.

Recommendations

85. We recommended that, the MHA should:

- Collaborate with the Central Medical Stores in the distribution of psychotropic medications by considering the patient turn out at treatment facilities to ensure that burdened (high patient visit) facilities are apportioned adequate medications for treatment of patients.
- Collaborate with the Ministries of Finance and Health to enhance the procurement process for the acquisition of psychotropic medicines for treatment of patients.

Management Response

86. Management agrees with the audit findings that there have been shortages and erratic supply of psychotropic medicines for the treatment of mental health conditions but suggested the audit team rephrase the "non-availability of the medicines" to "inadequacy and erratic supply of psychotropic medicines."

3.3.2 Inadequate monitoring by the MHA on alternative mental health treatment by Traditional and Faith-Based Healers

87. Traditional and Faith Based Healers (TFBH) provide alternative treatment for mental health cases to the orthodox means as carried out by the mental health units at health facilities. They provide psychiatric related services to patients in the treatment of metal disorders which are regulated by the Guidelines for Traditional and Faith Based Healers prepared by the Mental Health Authority.

88. According to the heads of selected TFBH, after patients are assessed, they determine whether to take patients through the traditional treatment or refer

them to orthodox care. Heads of TFBH interviewed stated that, they referred patients to formal health facilities when patients were aggressive and not responding to their mode of treatment. Thirty patients at the TFBH facilities revealed managers of the facilities allowed them to visit health facilities for treatment whilst they continued with the processes at the TFBH camps. We noted through inspections at the TFBH centres that, some centres chained some of their patients as they administer treatment to the patients. An example was Aposs Prayer Camp in Kibi where patients (aggressive ones) were chained by managers of the facility. Picture 3 shows a patient chained at the Aposs Prayer Camp in Kibi.

89. According to the deputy at the prayer camp, the patients were chained to prevent them from causing harm to other people in the prayer camp. The chained patients eat and defecate at the place chained. The deputy at the camp stated that, care givers and family members sign an agreement to give approval for the patient to be chained when necessary. The District Mental Health Officer stated that, his office has advised the owners of the prayer camp to refrain from chaining patients.

Picture 3: Chained patient at Aposs Prayer Camp-Kibi

Source: Audit team's field work (December 2020)

90. From our field visit and inspections at the Traditional and Faith Healing Centres, we noted that district community psychiatry nurses do not regularly visit healing centres to monitor their operations. They cited the lack of resources

(motor bicycles and fuel) to aid in monitoring the activities of the Traditional and Faith Healing Centres. Their inability to make frequent visits derailed the checks on the operational activities of Traditional and Faith-Based Healers.

91. According to the Guidelines for Traditional and Faith Based healers, the Mental Health Authority should train TFBHs on the rights of the Patients and how to handle metal health patients brought into their care. We noted that, the Authority had not conducted any training for TFBHs during the audit period 2016-2019. However, sampled regional mental health coordinators (Bono, Ashanti, and Volta regions) collaborated with mental health stakeholders (eg. Basic Needs, Humans Rights Advocacy Centre) to conduct training in mental health in 2019 for the TFBHs. Participants were trained on the rights of patients with mental illness, the importance of encouraging clients to be part of self-help groups as well as protection of the human rights of patients. According to the regional mental health coordinators, the initiative to engage stakeholders to train TFBHs was due to lack of funds for their operations.

92. According to sampled six regional mental health coordinators, they encouraged heads of mental health units to sensitize officials of TFBH when the heads embarked on outreach programmes. The heads advised the members of TFBH on the appropriate treatment procedures patients should be taken through. The Municipal and District Mental Health units trained the TFBH on the treatment they could offer to patients prior to referral to the treatment facilities. According to the heads of the TFBH, the training impacted positively on their operations as critical cases were referred to orthodox facilities for assessment and treatment.

Conclusion

93. The non-availability of resource for mental health monitoring activities at the regional and district levels affected the monitoring of mental health activities of Traditional and Faith Based Healing centres. This resulted in human rights abuses of some mental health patients in the care of TFBH Centres.

94. Also, the MHA did not carry out training of TFBH centres as the guideline of TFBH require them to do to improve their delivery of alternate mental health care service.

Recommendations

95. We recommended that, the MHA should:

- Ensure that district mental health officers regularly visit the TFBH centres to ensure TFBH centres abide by the guidelines on the treatment of mental patients including their human rights.
- Assist district mental health officers to design training programmes for TFBHs aimed at informing them on emerging issues regarding mental health care management. Also, the training programmes should be carried out regularly, recorded and evaluated to know its impact on their operations.

Management Response

96. Management acknowledged the observations that some Regional and District Mental health Coordinators did not visit some centres that practiced alternative and traditional mental health treatment in the country which are within the operations of the Authority. But management were of the view that the audit team's caption of "lack of monitoring by MHA is not accurate." The management proposed the audit team give the caption "inadequate monitoring by the Authority especially from the national level for the period under review."

3.3.3 Few professionals for mental health care service delivery

97. Section 3(n) of the Mental Health Act, 2012 (Act 846) requires the MHA to attract and retain the right mix of human resource through appropriate emoluments, remuneration, allowances and incentive package and conditions of service. This section entreats the authority to ensure proper mental health care is given to its clients by hiring the right number of professionals who are motivated to carry out their duties. Section 48 (6) of the Mental Health Regulations, 2019 (L.I. 2385) (a-f) states that the Head of a treatment facility shall ensure that the facility has the right staff mix which may include: a clinical psychologist, an occupational therapist, a medical doctor, a psychiatrist, a pharmacist, and a nurse to provide care to the mentally ill patients.

98. To carry out efficient and effective psychiatry services, the mix of the specialists comprising psychiatrists, psychologists, occupational therapists, staff nurses, and community psychiatry nurses must be available in all facilities. This mix of staff carry out assessment and prescription of drugs in the three main psychiatric hospitals for the effective delivery of mental health care to clients. According to the staff (other than psychiatrists), they assessed and prescribed drugs for clients under the supervision of the few psychiatrists to carry out such roles. For example, as at the time of the audit, Ghana had 40 psychiatrists. The psychiatrists to patient ratio was 1:750,000 compared with the standard of 1:100,000 proposed by the World Health Organisation for the African region[5]. This means Ghana's current population of 30 million should have a minimum of 320 psychiatrists.

99. The total number of psychiatrists that the three main psychiatric treatment facilities are required to have at the time of the audit were 22 but, the psychiatric treatment facilities had a total of nine (9) at post. According to the CEO of the MHA, there has been an increase in the number of psychiatrists from four at the inception of the Authority in 2012 to 40 as at the time of the audit in 2021. All the psychiatrists are distributed among the three main mental health facilities and the teaching hospitals nationwide. The Authority however could not provide information on other categories of professionals needed in the delivery of psychiatric care.

100. We noted that, 17 out of the 26 Psychiatrist available to MHA are in the Greater Accra and five in Ashanti Regions. We found the distribution skewed in favor of the two main cities because of lack of incentives and good working conditions available in the other regions and districts. Table 4 shows the distribution of mental health specialists at the three main psychiatric treatment facilities and selected teaching hospitals.

[5] *Atlas (Mental Health Resources in the World 2001 WHO)*

Table 4: Distribution of mental health specialists at the three main psychiatric treatment facilities and teaching hospitals

Category	Health facility	Clinical Psychologist	Psychiatrist	Occupational Therapist	Total
Psychiatry Hospitals	Accra Psychiatry Hospital	3	3	1	**7**
	Pantang Hospital	1	4	1	**6**
	Ankaful Psychiatry Hospital	-	2	1	**3**
Teaching Hospitals	Korlebu Teaching Hospital	2	10	1	**13**
	Komfo Anokye Teaching Hospital	2	5	1	**8**
	Tamale Teaching Hospital	-	1	-	**1**
	Ho Teaching Hospital	**1**	**1**	**-**	**2**
	Total	**9**	**26**	**5**	**40**

Source: Data from treatment facilities (November -December 2020)

101. Table 3 shows that, the three main psychiatric treatment facilities have 35% of the total number of psychiatrists working in the selected treatment facilities. However, the Korle Bu and Komfo Anokye Teaching hospitals psychiatric wings have 58% of total psychiatrists due to the facilities training of mental health professionals coupled with operation of specialised departments. On the whole, the seven facilities named in Table 3 has 65% of the total psychiatrist in Ghana. Aside the six psychiatrists at Tamale and Kumasi, all the rest are in the southern part of Ghana.

102. The three main mental health treatment facilities and teaching hospitals carry out training programmes for mental health professionals to improve service delivery. The training programmes carried out by the facilities took the form of refresher courses for practicing professionals, and psychiatric training for new general medical officers. These training programmes were to equip mental health professionals with the requisite knowledge to aid in the assessment and treatment of patients. The heads and members of the treatment facilities (the three main psychiatric and teaching hospitals) said that the professionals meet weekly to review cases and share knowledge on emerging issues in mental health treatment. The weekly professional review helps to boost the morale and confidence of junior professionals who are able to share their challenges on the job and have the opportunity to learn from their seniors.

103. In 2016, the MHA put in place the Professor Adgyakum's Annual Medical Students Debate on mental health amongst the Medical Schools to help build the interest of medical students in the field of mental health as a long-term plan of increasing the number of psychiatrist professionals. Winners of the debate are sent to Ireland for a month's affiliation in a psychiatric institution to gain exposure in mental health service care.

104. Selected regional, municipal and district health facilities visited did not have the required specialists such as psychiatrists and clinical psychologists for mental health treatment. Patients were assessed by staff nurses and community psychiatry nurses for mental health care.

105. The Koforidua Regional Hospital in collaboration with the Regional Coordinator for mental health organised on weekly basis a 'Clinico Pathological Meeting' where a psychiatrist is invited for consultation for all mental health cases in the region. According to the officials, the arrangement is to create an avenue for mental health patients in the region to have a professional touch of a psychiatrist during treatment.

Conclusion

106. The absence of key mental health specialists (psychiatrists and clinical psychologist) hindered on the effective delivery of mental health care service in the regional, municipal and district mental health facilities. This made psychiatry and staff nurses who were not qualified psychiatric specialist to assess and prescribe medicines for mental health patients.

Recommendations

107. We recommended that, the MHA should:

- Collaborate with the Ministry of Health to provide incentives to attract professionals to the mental healthcare sector.
- Develop a policy on training of mental health staff in psychiatric treatment facilities to improve on service delivery.
- Adopt the strategy used by the Koforidua Regional Hospital and the Regional Mental Health Coordinator on the "Clinico Pathological Meeting"

in the absence of mental health professionals in the regional and district hospitals to ensure more mental health patients experience some professional contact during treatment.

3.4 The Mental Health Fund is not delivering its intended purpose

108. Part of the object of the Mental Health Act, 2012 (Act 846) is to provide financial resources for the care and management of persons suffering from mental disorders. The Act listed in Section 81, that the Fund is to be used for the skills training of persons with mental disorders, any matter connected with the rescue, rehabilitation, and reintegration of persons with mental disorders; the construction of facilities for persons with mental disorders; and training, capacity building and research.

109. The Mental Health Fund is to be resourced from:

- voluntary contributions from individuals, organisations and the private sector,
- monies approved by Parliament for payment into the Fund,
- grants from bilateral and multilateral sources,
- donations and gifts; and
- monies from any other source approved by the Minister responsible for Finance.

110. We noted that, the projected sources of cash inflow into the fund have not been forthcoming as expected. The Authority largely depends on donations from individuals, corporate organisations, and development partners as their main source of funding to carry out selected operational activities. The Department for International Development (DFID) of the United Kingdom has been a consistent development partner that supports the Authority with its capacity building needs and other related programmes and activities.

111. During the audit period, individuals and development partners donated GH¢1,437,040.00 to the three main treatment facilities to assist them carry out some activities on mental health. The Development partners who donate, selected the kind of activities (e.g., Registration of patients on National Health Insurance Scheme (NHIS), purchase of equipment, sensitisation in the regions and radio talks) the funds were to be used for.

112. Treatment activities of the three main psychiatric treatment hospitals are to be funded from government subventions and from the Mental Health Fund.

However, government subventions during the audit period were not released in the amounts for operational activities of the MHA as required. Also, the Mental Health Fund as a complementary funding to that of government launched in 2018 to fund some specific activities of the MHA was not active as at the time of the audit. The MHA launched the Mental Health Fund in 2018 and realized GH¢10,000. After the launch, the Authority visited media houses to participate in shows to create awareness on mental health care and the need for the public and corporate organisations to donate to support the operations of the fund. According to the CEO, nothing substantial was gained out of the Authority's media engagement.

113. The Fund had an initial inflow of GH¢89,008.00 in 2015. We found from review of revenue and expenditure report on the Mental Health Fund that the monies were expended on selected objects of the Mental Health Fund which included capacity building and rescue of persons with mental disorder. But there was no evidence to support the activities carried with funds from the Mental Health Fund. As at the time of the audit, the fund had a closing balance of GH¢8,884.58. Table 5 shows details of the purpose for the funds and the actual items the funds were used for.

Table 5: Purpose and actual application of the Mental Health Fund from 2015-2019

Year	Inflows GH¢	Outflows GH¢	Intended Purpose	Actual use	Balance C/D GH¢
2015	89,008.00	2,754.60	• Skill training for person with mental disorder • any matter connected with the rescue, rehabilitation, and reintegration of persons with mental disorders • Rescue, rehabilitation, and reintegration of persons with mental health disorders, construction of facilities. • Training, capacity building and research	Printing of calendars	86,253.40
2016	41,900.00	114,119.89		Sensitisation (Workshop, printing in the regions)	14,033.51
2017	0-	5,148.93		Printing of epilepsy materials	8,884.58
2018	0-	0-		-	8,884.58
2019	0-	-0		-	8,884.58
Total	**130,908.00**	**122,023.42**		**-**	**-**

Source: Audit team's field analysis of the Mental Health Fund (January 2021)

114. We noted that donations into the fund had halted for over five years which made the Authority push for the approval of a Mental Health Levy as specified in Section 59 (4) of (L.I. 2385) to provide adequate funds to support its operational responsibilities. As at the time of the audit, we noted that the Mental Health

Levey had not been approved by the responsible approving authority to make it operational for the smooth running of mental health activities by the Mental Health Authority.

115. Within the years under review, the three main psychiatric treatment facilities carried out selected objectives of the Mental Health Fund. These were skills training of persons with mental disorders, their rehabilitation, reintegration, and training, capacity building and research. The three main psychiatric treatment facilities funded these activities with their Internally Generated Funds (IGF) and government subventions. The sources of funding for the IGFs were from consultations, medication, documentation, lodging and feeding, rehabilitation and laboratory services for patients.

116. Releases from Ministry of Finance for goods and services were inadequate which hampered the operations of the facilities in providing critical service to clients. To support treatment, the heads of the facilities mentioned they used fees from the services they rendered to clients to run the facilities.

117. Our inspection of the inpatient units within the facilities showed that, the facilities were over-burdened with patients who had to be treated and discharged but were neglected by families or unwilling to reunite with their families. Other patients had been dumped at the facilities with no trace of their families for reintegration. Caring for the patients increased the cost of feeding and treating patients to the facilities. Table 6 shows cost incurred by the three psychiatric facilities on paupers.

Table 6: Cost incurred on paupers/vagrants by the three psychiatric treatment facilities from 2016-2021

Facilities	2016 GH¢	2017 GH¢	2018 GH¢	2019 GH¢	2020 GH¢	2021 GH¢	Total Cost incurred on paupers GH¢	IGF for the Period GH¢
Accra Psychiatric Hospital	76,392.28	230,186.26	196,859.42	196,726.18	**2,564,900.11**	**3,262,006.99**	**6,527,071.13**	**8,883,469.91**
Pantang Hospital	-	342,567.86	296,878.26	191,885.30	**1,252,807.82**	**1,073,828.40**	**3,157,967.64**	**26,061,707.96**
Ankaful Hospital	3,603,178.99	2,221,746.14	1,173,000.55	1,044,122.27	**1,540,231.00**	**1,996,860.00**	**10,535,016.68**	**9,883,811.42**

Source: Audit team's field work analysis (January 2021)

118. From Table 6, Ankaful hospital spent about 6.6% more on caring for paupers than its IGF generated during the years under review. The Director of the facility mentioned that the high cost in caring for vagrants during the period under review was as result of debts owed to creditors for supplies used in the care of the vagrants hence, the cost was rolled over in ensuing years.

119. The inadequate release of government subventions to the MHA and the three main psychiatric treatment facilities resulted in the facilities not having the needed financial resources to execute their core functions of treating mental health patients which led to the facilities charging for services. The inadequacy of government subventions to the MHA is depicted in table 1.

Conclusion

120. The Authority could not mobilise support to increase donation into the fund apart from waiting for others to donate into it. Inconsistent cash inflows into the Mental Health Fund and lack of support from government hampered the operations of the MHA and the three main treatment facilities. This made the three main treatment facilities charge fees for mental health services contrary to Section 57 (2) of (L.I. 2385) which states that mental health service should be free.

Recommendations

121. We recommended that, the MHA should:

- Plan their activities and identify donors and corporate bodies that will be willing to support those activities, negotiate with them for support.
- Ensure monies donated into the fund are used for the purposes specified in the Act.
- Impress on Ministry of Finance to consider the case of the Mental Healthcare levy for implementation to address the financial challenges of the MHA, and

- Draw programmes to repatriate treated and sound patients to join their families for reintegration with the aim of reducing the cost of care on paupers/vagrants.

Management Response

122. Management stated that it is not accurate that the Mental Health Fund did not serve its purpose as generally captured. According to management, the amount that accrued in the fund was used on awareness creation, capacity building on Mental Health and patient evacuation in regions of Ghana though the Fund has been without adequate funding since its establishment.

123. Management stated it disagrees with the reviewers that the Mental Health Fund was not used for its intended purpose during the period under review. According to management key activities like printing of calendars for nationwide distribution containing customized and special messages about the newly created authority and its mandate on mental health treatment in Ghana, workshops on various mental health issues, printing of epilepsy treatment materials and evacuation of patients from the streets in some regions are all within the mandate of the Authority. Management mentioned that these are all part of capacity building and sensitization. Rescuing mentally ill patients are all part of the mandated activities as defined by the Mental Health Fund in the Mental Health Act, 2012 (Act 846).

Audit team's remarks

124. The Audit team has effected changes on the use of the Mental Health Fund per the additional information presented by the Authority. The details of expenditure carried on the use of the Mental Health Fund for the stated activities was not backed by documentary evidence. The Authority to expended 3%, 5.4%, 18%, and 18% respectively from the Mental Health Fund on rescue of mentally ill patients from the streets, printing of calendars, capacity building, and purchase of laptops. The Authority expensed 21.2% on goods and services with constituted the highest expenditure item on the use of the Mental Health Fund.

OVERALL CONCLUSION

125. The Mental Health Authority and the psychiatric treatment facilities although planned for awareness creation, the plans were not comprehensive and lacked indicators to help assess the performance of the plans. MHA did not carry out awareness creation activities effectively as planned as resources to enhance the activity was not forthcoming.

126. The Non-availability funds delayed the procurement process for psychotropic medicines which contributed to the inadequacy and erratic supply of the medicines at the time they were needed for treatment of mental health patients. The non-availability of resource for mental health in monitoring activities at the regional and district levels affected the monitoring of mental health activities of Traditional and Faith Based Healing centres. This resulted in human rights abuses of some mental health patients in the care of TFBH Centres. Also, the MHA did not carry out training of TFBH centres as the guideline of TFBH require them to do to improve their delivery of alternate mental health care service. The absence of key mental health specialists (psychiatrists and clinical psychologist) hindered on the effective delivery of mental health care service in the regional, municipal and district mental health facilities. This made psychiatry and staff nurses who were not qualified psychiatric specialist to assess and prescribe medicines for mental health patients.

127. The Authority could not mobilise support to increase donation into the fund apart from waiting for others to donate into it. The inconsistent cash inflows into the Mental Health Fund and lack of support from government hampered the operations of the MHA and the three main treatment facilities. The inefficiency in the operations of the Mental Health Fund was as a result of the non-passage of the Mental Health Levy proposed by the Mental Health Authority which has an object of complementing the support from the government.

APPENDICES

Appendix 'A'

Audit Questions and Assesment Criteria

Topic	Audit Question	Audit Criteria	Source
Planning of awareness creation	Does the community care department prepare plans for carrying out promotional activities on mental health care?	For MHA to ensure a reduction in the prevalence of mentally ill patients on the streets, we expect the MHA to have educated the public on the need to adopt preventive measures in reducing the prevalence of mentally ill patients. To achieve this, we expect the MHA to plan and budget for awareness creation programmes.	Section 2(c) of the Mental Health Act, 2012 (Act 846)
Execution of awareness creation plans	How are promotional activities on mental health carried out by the community care department? How often are promotional activities on mental health carried out by the community care department?	We expect MHA to implement planned activities to increase public awareness on mental health issues. Section 14(2)(a)(b) &(f) of the Mental Health Regulations, 2019, L.I. 2385 requires the MHA to employ and apply arts and media facilities for public education on mental health and engage the services of mental health counsellors for the promotion of mental health. The Section entreats	Section 6.1.1 of the MHA Strategic Plan 2014-2018 Sections 14(2)(a)(b) &(f) and 14(3)(a) &(b) of the Mental Health Regulations, 2019 (L.I. 2385)

		the authority to support mental health service users, carers and self-help support groups with appropriate information for community education and sensitisation on mental health. Also, Section 14(3)(a) &(b) puts the responsibility on the authority for the purpose of educating the public on mental health to issue publications and use the print and electronic media including films, leaflets, pamphlets, posters and signage to educate the public.	
Treatment of mentally patient	How are treatment processes carried out for persons with mental disorder? How does the Mental Health Authority monitor the operations of health facilities which carry out treatment on mentally ill patients? Are patients with mental disorder effectively treated at treatment facilities?	Section 57(4) of the Mental Health Act 2012, Act 846 requires persons with mental disorder to have access to psychotropic drugs and any other psychosocial rehabilitative interventions at different levels of care as appropriate. To ensure effective treatment of patients with mental disorder, we expect MHA to; • make available psychotropic medications at all levels of treatment for mental health patients to improve treatment conditions. • put in place policies/guidelines/protocols and follow same to ensure safe and quality	Section 57(4) of the Mental Health Act 2012, Act 846

		treatment of patients in all mental health treatment facilities.	
Professionals for mental health care service delivery	What plans and policies did MHA put in place to attract and retain the right mix of mental health professionals?	Section 3(n) of the Mental Health Act 2012, Act 846 requires the Authority to attract and retain the right mix of human resource through appropriate emoluments, remuneration, allowances and incentive package and conditions of service. Section 48 sub-section 6 of Mental Health Regulations, 2019 (L.I. 2385) (a-f) states that the Head of a treatment facility shall ensure that the facility has the right staff mix which may include: a clinical psychologist, an occupational therapist, a medical doctor, a psychiatrist, a pharmacist and a nurse to provide care to the mentally ill patients.	Section 3(n) of the Mental Health Act 2012, Act 846 Section 48 sub-section 6 of Mental Health Regulations, 2019 (L.I. 2385) (a-f)

Training of mental health officers	Did MHA organise continuing professional development programmes for its staff, collaborate with training institutions and NGOs to train mental health staff	Section 50 (4) (a) &(d) of the Mental Health Regulations, 2019 (L.I. 2385) entreats the MHA Board to collaborate with mental health training institutions, regulatory bodies, medical schools, universities and postgraduate institutions to provide training to staff. It also requires the Board to organise continuing professional development programmes for staff. Also, section 19 (c) of the Mental Health Regulations, 2019 (L.I 2385) charges heads of mental health facilities to ensure that staff of the facilities participate in continuing professional development programmes to improve knowledge and practice in mental health care.	Section 50 (4) (a) &(d) of the Mental Health Regulations, 2019 (L.I 2385) Section 19 (c) of the Mental Health Regulations, 2019 (L.I. 2385)
Training of Traditional and Faith Base Healers (TFBH)	Did MHA train TFBH and collaborated with relevant stakeholders to train TFBH	The MHA per its Guidelines for Traditional and Faith Based Healers (June 2018) is to train the TFBH on the Mental Health Act, 2012 (Act 846) and on the guidelines as well. The guidelines also require the MHA to collaborate with relevant stakeholders to train TFBH	MHA Guidelines for Traditional and Faith Based Healers (June 2018)
Monitoring of mental health activities by	Did PPME of Mental Health Authority	Section 6 (e) &(g) of the Mental Health Regulations, 2019, (L.I. 2385), tasks the Policy,	Section 6 (e) &(g) of the Mental Health

the PPME division of the MHA	monitored and evaluated the programmes and activities of the Authority and the treatment facilities as well as the regions to make informed decisions in the provision of mental health care?	Planning, Monitoring and Evaluation (PPME) Division of the MHA to monitor and evaluate the programmes of the Authority and to ensure that research activities are undertaken. It also puts responsibility on the PPME to periodically visit the regions to evaluate and monitor the activities of the Authority.	Regulations, 2019, L.I. 2385
Operation of mental health fund	How is Mental Health Fund providing financial resources for the care and management of persons suffering from health disorders?	Sections 80 and 81 (1) of the Mental Health Act, 2012 (Act 846), enacts the Mental Health Fund with its object to provide financial resources for the care and management of persons suffering from mental disorders. Sub-section 2 of paragraphs (a-d) of Section 81 of Act 846 requires the fund to be applied for the skills training of persons with mental disorders; any matter connected with the rescue, rehabilitation and reintegration of persons with mental disorders; the construction of facilities for persons with mental disorders; and training, capacity building and research.	Sections 80 and 81 (1) of the Mental Health Act, 2012 (Act 846)

Appendix 'B'

List of documents reviewed

No.	Documents	Reasons for review
1	Mental Health Act, 2012 (Act 846)	To know the mandate, vision, mission and objectives in the provision of mental health care delivery as well as the mental health policy that guides the operations and functions of the Mental Health Authority
2	Mental Health Regulations, 2019 (L.I. 2385)	To understand the structure of MHA, management and administration of Psychiatric Hospitals. It is also to know the requirements for the promotion of Mental health, the general protocols and procedures of Mental Health facilities, the standard of treatment clients are to receive at the health facilities. Again, it is also to know the licensing and management of private unorthodox mental Health facilities as well as the financing of Mental Health Care in the country.
3	Mental Health Strategic Plan 2014-2018	To know the programmes and activities put in place by the authority to improve mental health care delivery in the country
4	Guidelines for Traditional and Faith-Based Healers (June 2018)	To know how the Mental Health Authority collaborates and monitors the operations of the faith-based healers to improve treatment of patients who visit such facilities.

5	Financial documents, Annual Reports, and Monitoring and Evaluation Reports	To ascertain the level of implementation of the policies and plans as well as the impact of the implementation
6	Internal and external audit reports	To know risk areas identified in the operations of mental health care delivery in Ghana.
7	Training and capacity building	To know whether the training and capacity building programmes staff receive are ensuring quality service delivery.

Appendix 'C'

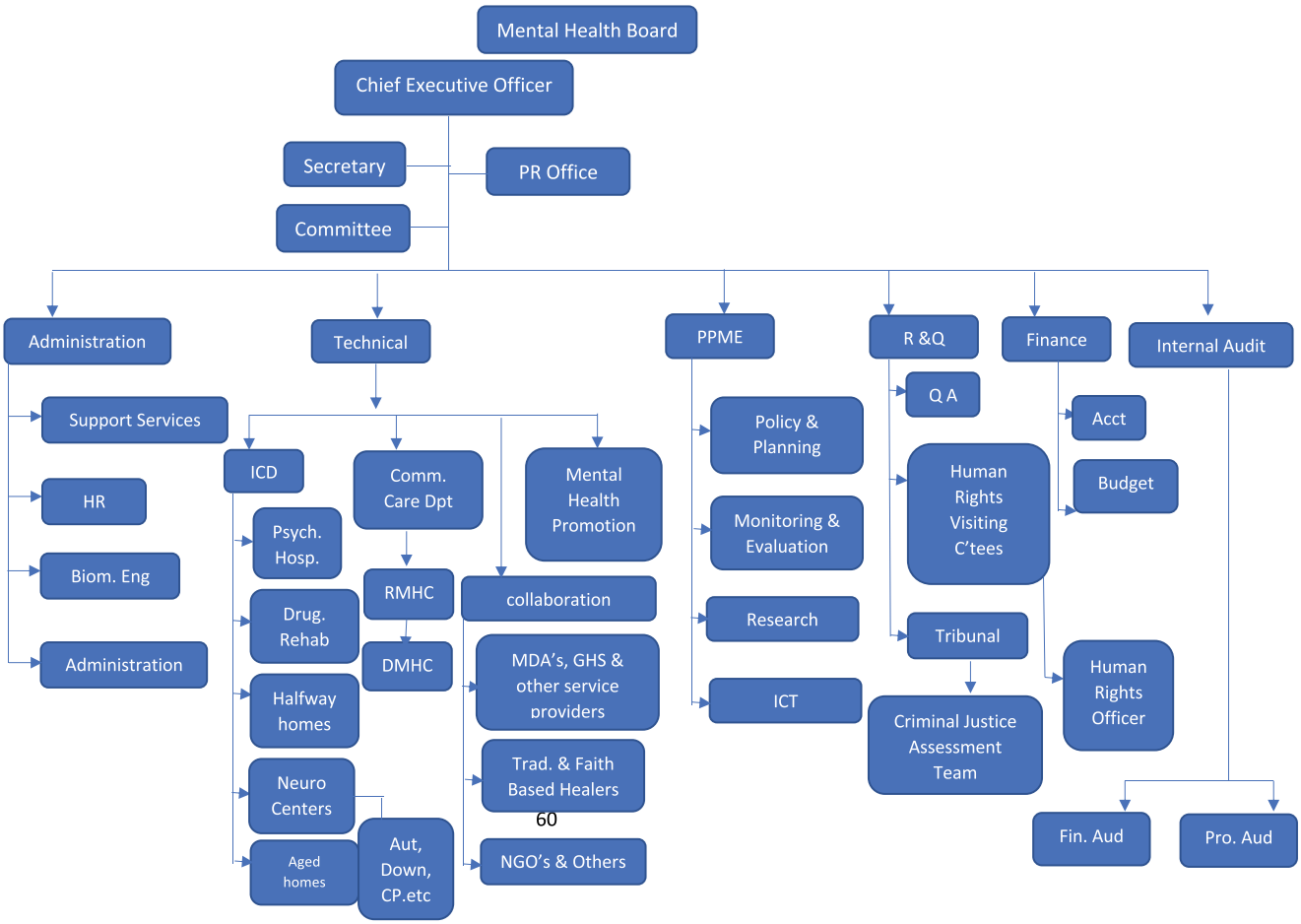
List of officers interviewed

No.	Officials interview	Reasons for the interview
1	CEO	To know the policy directives put in place for effective mental health care service delivery, as well as to know the successes chalked and the challenges faced by the Mental Health Authority in the delivery of mental health care in Ghana.
2	Deputy Director for Community Care	To understand the operations of the Mental Health Authority with regards to the treatment processes of mental health care delivery. It was also to know whether the authority planned and carried out awareness creation on mental health care to get the general public informed on mental health issues.
3	Deputy Director for Pharmaceutical Services	To know whether the medications needed for the treatment of mentally ill patients are readily available in their right type and quantities for administration to patients and economical to access.
4	Director for Policy Planning, Research Monitoring & Evaluation	To know how the activities of the treatment facilities were monitored within the audit period for improved service delivery.
5	Acting Director for Finance	To know how mental health activities were funded within the audit period for improved service delivery.

6	Psychiatric Hospital Directors	To ascertain the role they play regarding awareness creation, treatment of mental health patients and monitoring of mental health activities and service delivery
7	Psychiatrist	To know the roles, they play in the mental health care delivery
8	Clinical Psychologist	To know the roles, they play in the mental health care delivery
9	Procurement officers	To know the roles, they play in the mental health care delivery
10	Community Mental Health Officers	To know how they create awareness on mental healthcare and treat mentally ill patients
11	Traditional and Faith Base Healers	To know how they treat mentally ill patients as they happened to be the first point of call within the communities as mentally ill cases are presumed to be spiritual.
12	Occupational Therapist	To know the roles, they play in the mental health care delivery

Appendix 'D'

Mental Health Authority Organogram



Appendix 'E'

System description for mental health delivery in Ghana

The processes of carrying out mental health care is discussed below:

PROMOTION / PREVENTION:

The first step in the promotional activities is the development of draft messages such as jingles, pictorials, audio-visuals, among others to be used in carrying out the awareness creation. The MHA requests for inputs from stakeholders on prevailing mental health issues prior to the development and implementation of mental health educational programmes. MHA pretests the messages developed to ascertain whether the content of the draft message captures relevant information and if implemented will impact positively on the general public. MHA then finalizes the developed audio-visual messages, train available staff with the needed knowledge to carry out awareness and roll out the finalized messages. The rolling out involves the use of the mass media, which include radio, television, billboards, print material and internet. Interpersonal channels, such as group presentations and community mobilization are also used to undertake the promotion.

TREATMENT:

Treatment of mental health patients are integrated into the general health care system. Mental health patients are expected to enter into any of the District, Regional, Teaching Hospitals and the three main psychiatric hospitals in Ghana to receive treatment. The patient is required after entering the facility to go to the Outpatient Department (OPD) for registration and collection of folders. New patients are to be given new folders whilst old patients' folders are retrieved for processing. After the registration of patients, the vitals (BP, temperature, weight among others) are taken where patients are then assigned to doctors for

consultation. Diagnosed patients are either treated and discharged or referred for further examination (laboratory tests/x-ray scan) and treated. However, patients are referred to specialist after further examinations show they need the services of a specialist for treatment. Patients' examined by doctors are given prescribed medicines for administration to improve on their condition. Notwithstanding, patients who happen to lose their livelihood after treatment are referred for rehabilitation/reintegration to enhance their livelihood for economic independence.

REHABILITATION/REINTEGRATION:

The MHA is to ensure that mental health patients are reintegrated into society after recovery, it is expected that MHA will put in place a programme that will totally transform the recovery of the patient. The MHA is to have a comprehensive care plan such as wellness recovery plan and livelihood empowerment plan (occupational therapy) to facilitate the reintegration of treated patients. Clinical psychologists in the process of rehabilitation/reintegration, are responsible for counselling patients after they have gone through psychotropic treatment. For each patient, service providers come up with plans which are tailored specifically to the needs of that patient. In doing so, these service providers, also known as occupational therapists, assess each client based on their individual skills and interests in order to develop wellness recovery plans. In order to carry out rehabilitation/reintegration, there is usually a collaboration between the service providers, social workers and clinical psychologists. A team made up of social workers is responsible for visiting the family of clients in order to prepare them for the return of their mental health patients.

Table 11: The staff mix of the three main psychiatric hospitals and selected health facilities visited

Health facility	Clinical Psychologist	Psychiatrist	Occupational Therapist	Nurse	Pharmacist	Total
Accra Psychiatry Hospital	3	3	1	2	2	**11**
Pantang Hospital	1	4	1	4	1	**11**
Ankaful Psychiatry Hospital	1	2	1		1	**5**
Korlebu Teaching Hospital	20	10	1			**31**
Komfo Anokye Teaching Hospital	2	5				**7**
Tamale Teaching Hospital	1	2				**3**
Ho Regional Hospital				8		**8**
Tamale Regional Hospital						**0**
Sunyani Regional Hospital	1	0		4		**5**
Agona Swedru Municipal Hospital	0	1		4		**5**
Cape Coast Metropolitan Hospital	0	0	0	4		**4**
Begoro District Hospital	0	0	0	4		**4**
Kibi Gov't Hospital	0	0	0	2		**2**
Nsawam Gov't Hospital	0	0	0	5		**5**
Eastern Regional Hospital	1	3	1			**5**
Akatsi Gov't Hospital	0	0	0	4		**4**
Sunyani Municipal Hospital	0	0	0	8		**8**
Ejisu Gov't Hospital	0	0	0	5		**5**
Konongo Gov't Hospital	0	0	0	3		**3**
Juaso Gov't Hospital	0	0	0	3		**3**
Tolon Health Centre	0	0	0	2		**2**
Kintampo Municipal Hospital	0	0	0	5		**5**
Tamale West Hospital	0	0	0	4		**4**
Savelugu Municipal hospital	0	0	0	6		**6**
Winneba Municipal Hospital	0	0	0	4		**4**
Agona Swedru Municipal Hospital	1	0	0	5		**6**
St Anthony Hospital Dzodze	0	0	0	2		**2**
Ho Municipal Hospital	0	0	0	8		**8**

Mission Statement

The Ghana Audit Service exists

To promote

good governance in the areas of transparency, accountability and probity in Ghana's Public financial management system

By auditing

to recognised international standards and reporting our audit results

And

reporting to Parliament