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The Role of Mental Health Legislation and Governance in Program Delivery: An Analysis of Ghana's Mental Health Act 846 (2012)

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Abstract

Mental health legislation plays a critical role in shaping equitable and rights-based service delivery, particularly in low- and middle-income countries. In 2012, Ghana passed the Mental Health Act (Act 846) to decentralize care, protect the rights of persons with mental health conditions, and integrate mental health into general health services. This study examines the extent to which the Act has influenced mental health program delivery in Ghana, using qualitative data from 20 key stakeholders across the Western Region and national-level institutions. Data were collected through semi-structured interviews and document review and analyzed thematically. The findings reveal that although awareness of the Act exists among stakeholders, its implementation has been hindered by weak institutional coordination, inadequate funding, limited decentralization, and absence of a Legislative Instrument. Rights-based provisions and regulation of traditional healing practices remain largely unimplemented. The study concludes that Ghana's mental health legislation, while progressive on paper, requires targeted governance reforms, operational clarity, and sustained political will to translate policy into practice. It calls for immediate passage of the supporting Legislative Instrument, improved inter-agency coordination, and culturally grounded stakeholder engagement to ensure full realization of the Act's goals.

Keywords: Mental Health Act, Governance, Policy Implementation, Mental Health Services, Ghana

Introduction

Mental health is an indispensable component of overall well-being, yet it continues to receive inadequate attention in policy and practice, particularly in sub-Saharan Africa (Saraceno et al., 2007; WHO, 2013). In Ghana, the mental health sector has historically been under-resourced, overly centralized, and stigmatized, with limited community-based care options and a critical shortage of mental health professionals (Adu-Gyamfi & Brenya, 2016; Doku et al., 2012). To address these structural deficits, Ghana passed the Mental Health Act, Act 846, in 2012, which was heralded as a landmark legislation aimed at ensuring rights-based care, promoting decentralization, regulating traditional and faith-based practices, and enhancing access to mental health services (Republic of Ghana, 2012; Osei et al., 2013).

However, despite the ambitious provisions of the Act, implementation has been slow and fraught with systemic challenges. The Mental Health Authority, which was established under the Act to coordinate mental health policy and services, continues to grapple with

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inadequate budgetary allocations, logistical constraints, and limited autonomy (Osei, 2017). More than a decade after the law's enactment, key provisions such as the full establishment of regional mental health subcommittees, adequate integration into the National Health Insurance Scheme (NHIS), and enforcement of rights protections remain largely unfulfilled (Amoako & Owiredu, 2020). Mental health services remain heavily concentrated in three major psychiatric hospitals—Accra, Pantang, and Ankaful—with insufficient coverage across the rural and peri-urban areas (GHS, 2021).

Moreover, the persistent gap between mental health legislation and service delivery reflects deeper governance issues such as weak institutional accountability, poor intersectoral collaboration, and limited stakeholder engagement (Roberts et al., 2008). The structural weaknesses in implementation raise critical questions about the role of legal and policy instruments in improving mental health outcomes in low-resource settings like Ghana.

This study therefore seeks to examine the impact of the Mental Health Act 846 on mental health program delivery in Ghana, with particular focus on the legislative, institutional, and governance mechanisms that support or hinder its implementation. By interrogating the policy-practice disconnect, the study contributes to the broader discourse on health governance, systems reform, and mental health rights in developing countries.

Methodology

This study adopted a qualitative case study design to explore the extent to which the Mental Health Act 846 (2012) has influenced mental health program delivery in Ghana. The choice of this design was informed by the need to obtain in-depth, contextual insights into the legal, institutional, and governance structures surrounding the implementation of the Act (Yin, 2011).

Study Area and Population

The study was conducted in the Western Region of Ghana, with participants drawn from mental health institutions, district health directorates, civil society groups, and traditional authorities involved in community health. Key actors from the Mental Health Authority and selected NGOs working in mental health were also included. The selection of the Western Region was based on its representation of both urban and rural health dynamics, as well as documented challenges in mental health service delivery (Elliason, 2017).

Sampling and Participants

A purposive sampling technique was employed to select 20 key informants comprising mental health professionals, health administrators, policymakers, and representatives of civil society. The selection criteria included professional experience in mental health service delivery, familiarity with the provisions of the Mental Health Act, and involvement in policy implementation or advocacy. Snowball sampling was also used to reach additional stakeholders

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who were recommended during field interactions.

Data Collection Techniques

Data were collected using semi-structured interviews and document reviews. The interviews focused on participants' perspectives on the effectiveness of the Mental Health Act, institutional readiness, barriers to implementation, and governance challenges. Policy documents, legislative reports, budget allocations, and annual reports from the Ghana Health Service and Mental Health Authority were also reviewed to triangulate findings and enrich contextual understanding.

Data Analysis

Data were transcribed and analyzed thematically using the framework approach (Ritchie & Spencer, 1994). Themes were developed inductively and deductively based on the research objectives and emerging patterns from the data. Key themes included policy awareness, legislative enforcement, inter-agency coordination, resource availability, and rights protection.

Ethical Considerations

Ethical approval was obtained from the institutional review board of Atlantic International University, and informed consent was secured from all participants. Participants were assured of anonymity, confidentiality, and the voluntary nature of their participation.

RESULTS

Demographic Characteristics of Participants

The study involved 20 purposively selected key informants, including mental health professionals, district health administrators, policymakers, and civil society actors across the Western Region of Ghana and the national level. The demographic characteristics of participants are presented in Table 1.

Table 1: Demographic Profile of Participants (N = 20)

Characteristic	Category	Frequency (n)	Percentage (%)
Gender	Male	12	60.0
	Female	8	40.0
Age Group	30–39 years	4	20.0
	40–49 years	9	45.0
	50 years and above	7	35.0

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Professional Category	Mental Health Professionals	6	30.0
	District Health Administrators	5	25.0
	Policy-Level Officials	4	20.0
	Civil Society Representatives	5	25.0
Years of Experience	Less than 5 years	2	10.0
	5–10 years	7	35.0
	Above 10 years	11	55.0

The majority of participants were male (60%), with most falling within the 40–49 age group (45%), followed by those aged 50 years and above (35%). The study sample reflected a cross-section of stakeholders with diverse professional backgrounds relevant to mental health governance. Most participants (55%) had over 10 years of experience, indicating a well-informed and experienced respondent base for evaluating the implementation of the Mental Health Act.

Awareness and Understanding of the Mental Health Act

Findings indicated that while 80% of participants were aware of the existence of the Mental Health Act 846 (2012), only 40% had in-depth knowledge of its key provisions. Mental health professionals demonstrated relatively higher familiarity with the Act compared to administrators and civil society actors. Several district-level actors reported that no formal training or dissemination had been conducted at their level.

"We have heard of the Act, yes, but we were not given any official orientation or training. We mostly rely on our own reading or workshops organized by NGOs." — District Health Director

Perceived Impact of the Mental Health Act on Program Delivery

Despite the recognition of the Act's potential, most respondents agreed that its actual impact on mental health program delivery has been limited. Key reasons cited include weak institutional structures, poor funding, and lack of political will. Only 25% of respondents reported any noticeable improvement in service delivery attributable to the Act, such as increased community sensitization and advocacy engagements.

"The Act is excellent on paper, but in practice, very little has changed. Facilities still lack medication, trained staff, and logistics." — Senior Psychiatric Nurse

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Institutional and Governance Barriers to Implementation

Participants cited multiple institutional barriers impeding implementation of the Act. These included:

- **Inadequate funding**: Over 70% of participants emphasized the absence of dedicated financial resources to operationalize the Act.
- **Limited staffing**: Many districts lacked mental health professionals to lead implementation efforts.
- **Poor inter-agency coordination**: Respondents observed fragmentation between the Ghana Health Service, Mental Health Authority, and other implementing bodies.
- **Absence of Legislative Instrument (LI)**: Delays in passing the LI were repeatedly mentioned as a critical bottleneck to enforcement and regulation.

"Without a Legislative Instrument, many provisions in the law remain theoretical. There is no bite to the bark." — Policy-Level Official

Decentralization and Service Accessibility

The goal of integrating mental health into primary care at the district and sub-district levels has seen minimal progress. Respondents from rural districts reported that mental health services were either unavailable or grossly under-resourced. Only three participants indicated that their districts had designated mental health focal persons.

"In the rural areas, patients still travel to the regional capital to access any form of psychiatric care. The decentralization promised by the Act is far from reality." — NGO Representative

Rights Protection and Traditional Healing Practices

The Act's provisions for regulating traditional and faith-based healing practices are largely unenforced. Respondents noted the continued prevalence of unregulated healing camps where patients are chained or denied medication. Only two participants reported any attempt by local authorities to engage or register such centers under the Act.

"There are laws against chaining, but who enforces them? Families still send relatives to prayer camps because there is no alternative." — Civil Society Advocate

Discussion

The findings of this study provide significant insights into the challenges and gaps surrounding the implementation of the Mental Health Act, Act 846 of 2012, in Ghana. Although the passage of the Act was widely welcomed as a progressive step toward improving mental health governance and rights-based care, its impact on actual service delivery remains limited. The data revealed that while most stakeholders were aware of the Act's existence, few had detailed knowledge of its provisions. This lack of awareness,

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especially among district-level implementers, reflects the broader problem of poor dissemination and capacity-building around mental health legislation in Ghana, a challenge also noted by Ofori-Atta, Read, and Lund (2010).

The findings underscore the persistent disconnect between legislation and practice. Participants consistently pointed to the limited influence of the Act on transforming service delivery systems. This is not surprising, given that the Act's implementation has been hindered by weak institutional commitment and insufficient financial backing. As documented by the World Health Organization (2017), effective mental health legislation requires dedicated financing and operational mechanisms, without which policy intentions remain unrealized. Ghana's Mental Health Authority, though legally mandated to lead implementation efforts, continues to operate with inadequate autonomy and resources, as also highlighted by Osei (2017) and Doku et al. (2015).

In terms of institutional governance, the study revealed systemic weaknesses in the coordination between the Ministry of Health, the Ghana Health Service, and the Mental Health Authority. Respondents frequently alluded to overlapping responsibilities, fragmented communication, and lack of clear leadership. These governance gaps mirror similar findings by Adu-Gyamfi and Brenya (2016), who argue that Ghana's health governance framework often fails to promote coherent inter-agency collaboration. The absence of a Legislative Instrument (LI) to support enforcement mechanisms was cited as a major implementation bottleneck. The delay in passing this subsidiary legislation has left many regulatory and operational clauses in the main Act dormant, as enforcement structures remain legally and logistically weak.

An important finding relates to the decentralization agenda outlined in the Act. Although the legislation proposes the integration of mental health into district-level primary care, the practical execution of this mandate has been poor. This study corroborates earlier research by Read and Doku (2012), who identified the limited spread of mental health services beyond Accra, Pantang, and Ankaful psychiatric hospitals. Participants in this study reported that most rural districts lacked dedicated mental health staff or facilities, compelling patients to travel long distances to access care. This situation reinforces the urban–rural disparity in health service access and contradicts the equity-based principles embedded in the Act.

Another critical concern raised by respondents was the failure to regulate traditional and faith-based healing practices, despite clear legislative provisions. The continued existence of healing camps where persons with mental health conditions are chained and subjected to harmful treatments reflects a profound gap between legal mandates and cultural realities. Although the Act acknowledges the role of traditional healers and seeks to regulate them, no substantial progress has been made in registering or training these

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practitioners. This confirms prior reports by Human Rights Watch (2014) and underscores the complexities of enforcing biomedical mental health frameworks in contexts where spiritual and cultural interpretations of illness remain dominant.

The findings from this study carry important policy implications. Firstly, for the Mental Health Act to have a meaningful impact, there must be a national strategy to increase awareness of its provisions among health workers, traditional authorities, and the general public. Secondly, the Ministry of Health should expedite the passage of the Legislative Instrument to enable full enforcement of the law. Thirdly, decentralization efforts must be supported with budgetary allocations, human resource recruitment, and technical support to district health directorates. Without such systemic investment, the call to integrate mental health into primary care will remain aspirational. Finally, a comprehensive engagement strategy is needed to incorporate and regulate traditional healing systems. This must be done sensitively but firmly, aligning cultural practices with basic human rights principles as outlined in the Act and by global mental health frameworks (Patel et al., 2018).

This study is not without limitations. The purposive sample of 20 participants, while rich in expertise, may not fully capture the breadth of experiences across all regions of Ghana. The reliance on self-reported perspectives also introduces subjectivity, though this was mitigated by triangulation with policy documents and reports. Additionally, due to time and resource constraints, a broader quantitative survey was not conducted to validate perceptions on a larger scale. Future studies may build on this work by conducting longitudinal assessments and comparative analyses across regions to measure implementation progress over time.

Conclusion

This study has demonstrated that although Ghana's Mental Health Act 846 (2012) presents a robust framework for promoting rights-based, accessible, and integrated mental health care, its impact on program delivery remains limited more than a decade after its passage. The challenges lie not in the content of the legislation but in the absence of strong implementation mechanisms, inadequate funding, poor institutional coordination, and limited public and professional awareness. Moreover, the failure to engage traditional and community-based actors undermines the Act's relevance within the local context.

Addressing these gaps requires deliberate and sustained efforts by government, civil society, and development partners. The legislative gains must be matched by operational reforms, adequate budget allocations, and targeted training programs. Only then can the promise of the Mental Health Act move from paper to practice, and mental health care in Ghana achieve the transformation it so urgently requires.

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