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Mental health and exploitation, violence and abuse: the domestication of articles 5 and 16 of the African Charter on Human and Peoples' Rights in Ghana and its implication for conventional and traditional mental healthcare

*Natalie Schuck**

ABSTRACT: This article assesses the critical situation of inhumane and degrading treatment in the mental healthcare practice through a review of the interaction between the right to health and the right to be free from exploitation, violence and abuse. The article reflects on the domestication of articles 5 and 16 of the African Charter on Human and Peoples' Rights and the status of exploitation, violence and abuse in conventional and traditional mental healthcare in Ghana. Since the enactment of the Ghanaian new and progressive mental health law in 2012, specific measures have been put in place to advance the protection of persons within the mental healthcare setting: mental healthcare workers, including traditional and faith-based practitioners, have been trained on human rights; guidelines have been published; and programmes such as the QualityRights initiative have been launched. A normative analysis, combined with literature review, interviews and field visits, help to uncover barriers impeding implementation of the law and reveal gaps that remain, which automatically leaves room for exploitation, violence and abuse. The paradigm shift from a rather paternalistic approach in mental healthcare to one that promotes and respects autonomy and dignity is slow. There is still much to be desired. This article argues that there is a need to reassess or further define domestic legal provisions allowing for involuntary treatment and restraints, establish a stronger human rights oversight body, strengthen cooperation between the formal and informal mental healthcare providers, and create a legal forum where persons whose rights have been infringed can seek redress. Ultimately, these advancements could ensure that the provided right, namely to be free from exploitation, violence and abuse in mental healthcare, translates into actual change.

TITRE ET RÉSUMÉ EN FRANCAIS:

Santé mentale et exploitation, violence et abus: l'incorporation en droit interne des articles 5 et 16 de la Charte africaine des droits de l'homme et des peuples et son incidence sur le système conventionnel et traditionnel des soins de santé mentale au Ghana

RÉSUMÉ: Cette contribution examine la question des traitements inhumains et dégradants dans la pratique des soins de santé mentale à travers une analyse de l'interaction entre le droit à la santé et le droit de ne pas être soumis à l'exploitation, à la violence et aux abus. L'article se penche sur l'incorporation en droit interne des articles 5 et 16 de la Charte africaine des droits de l'homme et des peuples et sur l'état

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des lieux de l'exploitation, de la violence et des abus dans les soins de santé mentale conventionnels et traditionnels au Ghana. Depuis que la loi sur la santé mentale au Ghana a été promulguée en 2012, des mesures spécifiques ont été mises en place pour renforcer la protection des personnes impliquées dans le système des soins de santé mentale: des agents de santé mentale, notamment les tradi-thérapeutes et guérisseurs religieux, ont suivi une formation sur les droits de l'homme; des directives ont été publiées; et des programmes tels que l'initiative « Quality Rights » ont été mis en œuvre. Cette contribution se fonde sur une analyse normative et doctrinale, d'entretiens et de visites de terrain pour appréhender les obstacles à la mise en œuvre de la loi et de révéler les lacunes qui subsistent. Ces dernières continuent à causer l'exploitation, la violence et les abus. Le changement de paradigme, c'est-à-dire d'une approche paternaliste en matière de santé mentale vers une approche qui favorise et respecte l'autonomie et la dignité, est plutôt lent. Il reste donc fort à faire. Cette contribution postule qu'il est nécessaire de réévaluer ou de définir les dispositions légales nationales permettant un traitement et des contraintes involontaires, de mettre en place un organe de protection des droits de l'homme plus efficace, de renforcer la coopération entre les prestataires formels et informels de soins de santé mentale et de créer un forum juridique où les victimes des violations des droits de l'homme peuvent demander réparation. À terme, ces progrès pourraient faire en sorte que le droit prévu, à savoir de ne pas être soumis à l'exploitation, à la violence et aux mauvais traitements en matière de santé mentale, se traduise en un changement réel.

KEY WORDS: mental health, right to health, freedom from exploitation, violence and abuse, freedom from inhumane treatment, Mental Health Act, Ghana

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1 INTRODUCTION

The domestication and implementation of articles 5 and 16 of the 1981 African Charter on Human and Peoples' Rights (African Charter), dealing with the prohibition of cruel, inhuman and degrading treatment and the right to health, form an integral component of the emerging legal research about mental health and human rights. Within the last few years, many scholars have written about the human rights situation of persons with mental health conditions,¹ and the United Nations Human Rights Council has also supported the establishment of

1 Eg D Bhugra *et al* (eds) 'The right to mental health and parity' (2015) 57 *Indian Journal of Psychiatry* 117; E Flynn *et al* (eds) *Global perspectives on legal capacity reform: our voices, our stories* (2018); A Arstein-Kerslake *Restoring voice to people with cognitive disabilities: realizing the right to equal recognition before the law* (2017); and P Barlett & M Schulze 'Urgently awaiting

a human rights approach to mental health.² As the importance to protect persons with mental health conditions against violence and abuse grew in recognition, numerous countries developed new mental health laws and policies aimed at the protection of this vulnerable group, amongst them many African countries. Nevertheless, state compliance with regional but also domestic legislation remains a challenge, as is the case in Ghana. Accordingly, this article inquires about the status of the law and mental healthcare structures in Ghana. It sets out to determine the factors that impede the protection against ill-treatment in the mental healthcare service delivery, a system where power imbalances reinforce paternalism and patriarchal approaches.

This article takes a human rights approach to discuss the status of exploitation, violence and abuse in mental healthcare in Ghana in reference to articles 5 and 16 of the African Charter. Practically, this article is a reflection on the improvements made in domestic law, the challenges remaining and the prospects of advancing the human rights protection in the mental healthcare system. The term ‘mental healthcare’ or ‘mental healthcare system’ is used in the paper, to refer to the sum of all existing services, including conventional and traditional mental healthcare, as suggested by the World Health Organisation (WHO);³ traditional mental healthcare comprising the practice of traditional and faith-based healers. Without explicitly excluding outpatient facilities, this article refers to ill-treatment after admission to facilities, and hence, looks at human rights violations regarding inpatient mental health services. Therefore, the domestication and implementation of articles 5 and 16 of the African Charter for the purpose of this article has to be understood in a rather narrow scope. The article commences with a normative analysis of the respective articles of the African Charter and the applicable domestic framework. Following is an assessment of the actual status of exploitation, violence and abuse in mental healthcare in Ghana and thus the implementation of the law and the challenges that persist. The final part of the article concludes with an examination of gaps and shortcomings of the regional and domestic human rights protection, supplemented with policy and program recommendations for Ghana, where practicable leaned on best-practice examples from other African countries.

implementation: the right to be free from exploitation, violence and abuse in article 16 of the Convention on the Rights of Persons with Disabilities’ (2017) 53 *International Journal of Law and Psychiatry* 2.

- 2 See eg United Nations General Assembly (UNGA) ‘Report of the United Nations High Commissioner for Human Rights, Mental health and human rights’ (31 January 2017) UN Doc A/HRC/34/32; and ‘Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ (28 March 2017) UN Doc A/HRC/35/21.
- 3 World Health Organisation (WHO) ‘Organization of services for mental health (Mental Health Policy and Service Guidance Package)’ (2003).

2 THE PROTECTION OF PERSONS WITHIN THE MENTAL HEALTHCARE SYSTEM AGAINST EXPLOITATION, VIOLENCE AND ABUSE UNDER THE AFRICAN CHARTER

The African Charter establishes a system for the promotion and protection of human rights within the African region. It incorporates civil and political rights, like the right to be free from inhumane and degrading treatment, in the same document as economic, social and cultural rights, such as the right to health.

2.1 The right to health

Being part of the internationally recognised economic, social and cultural rights,⁴ the right to physical and mental health is also protected under the African human rights system. Article 16 of the African Charter provides for the right to enjoy the best attainable state of physical and mental health and obliges state parties to take all necessary means to (i) protect the health of the people and (ii) ensure that the sick receive medical attention.⁵ Although (i) is of no lesser importance in the discussion about the right to mental health, this article focuses on (ii) as it explores how persons who have already fallen mentally ill, receive mental healthcare. At first, article 16 was criticised for being too vague and for lacking specific measures that states have to take to implement the right.⁶ However, guidelines, resolutions and case-law of the African Commission on Human and Peoples' Rights (African Commission) have interpreted the right since the adoption of the African Charter and thus, resolved such criticisms.

Among those interpretive soft law instruments is the 2004 Pretoria Declaration on Economic, Social and Cultural Rights in Africa, in which the African Commission explains that article 16 entails the '[a]vailability of accessible and affordable health facilities, goods and services of reasonable quality for all', '[a]ccess to humane and dignified care for persons with mental and physical disabilities', and '[t]raining for health personnel including education on health and human rights'.⁷ The Principles and Guidelines on Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights, adopted in 2010,

4 See eg UNGA, International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3, art 12.

5 Organization of African Unity, African Charter on Human and Peoples' Rights (Banjul Charter) (adopted 27 June 1981, entered into force 21 October 1986) 1520 UNTS 271, art 16(1)(2).

6 M Ssenyonjo 'Analysing the economic, social and cultural rights jurisprudence of the African Commission: 30 years since the adoption of the African Charter' (2011) 29 *Netherlands Quarterly of Human Rights* 358 362-363.

7 African Commission, Pretoria Declaration on Economic, Social and Cultural Rights in Africa (adopted on 17 September 2004), para 5.

stipulate further components of the right to mental health: the right to healthcare, which is effective and integrated; the freedom to have control over one's own body and health; and the right to be free from unwarranted interferences, such as non-consensual medical treatment or inhumane and degrading treatment, among others.⁸ Defined as minimum core obligations, states must ensure the right to access health facilities, goods and services on a non-discriminatory basis for especially vulnerable groups, which includes early diagnosis and access to humane and dignified care and treatment specifically for persons with mental disorders.⁹ Both documents explicitly address the vulnerability of persons with mental disorders and the need to protect them against abuse within the mental healthcare system. Since traditional healthcare plays a special role in general but particularly for mental healthcare, it is important to note that the Principles and Guidelines furthermore urge states to recognise, accept, develop and integrate traditional healthcare into the public healthcare system, which includes drafting legislation on traditional medicine and creating an oversight authority, in order to protect individuals from abuse and misuse of traditional medicine and practice.¹⁰

As the African Charter states, its provisions can be supplemented by special protocols, if necessary.¹¹ For that reason, I would like to draw the attention to article 17 of the 2018 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (Protocol on Disability Rights), which provides detailed regulations regarding the right to health of persons with mental disabilities. For instance, it states that persons with mental disabilities should have the same range, quality and standard of healthcare as provided to others, and that specific services designed to minimise or prevent further mental disability need to be offered, including the provision of medicine. The article highlights that healthcare has to be provided on the basis of free, prior and informed consent, that persons with mental disabilities should be supported in the decision making, if needed, and that all healthcare providers, including conventional and traditional services, do not violate any rights of persons with mental disabilities.¹²

The African Court of Human and Peoples' Rights (African Court) has to be seen as important institution with immense potential to enhance the standard of human rights protection in the African region.¹³ Nevertheless, there has not been any ruling on the right to

8 African Commission, Principles and Guidelines on Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights (November 2010), paras 62, 64 & 65.

9 n 8 above, paras 1(e) & 67(a)(ee).

10 n 8 above, para 67(h)(w).

11 Banjul Charter (n 5) art 66.

12 African Union, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (adopted 29 January 2018), art 17.

13 See eg D Juma 'Provisional measures under the African human rights system: the African Court's order against Libya' (2012) 30 *Wisconsin International Law Journal* 344 363.

health in which the Court discussed the substantive essence of the right,¹⁴ neither was the right to health interpreted any further in orders of provisional measures which address the right.¹⁵

The African Commission, on the other hand, has interpreted the human right to health as quasi-judicial body in several instances.¹⁶ In a landmark case for mental health, *Purohit & Another v The Gambia*, the claimants alleged that the Gambia is violating the human right to health of persons with mental disorders, as the Lunatic Detention Act (LDA) uses discriminatory labels for affected individuals and orders their detention in psychiatric jails which lack quality diagnosis and treatment. The African Commission considered that additionally to the right to access health facilities, goods and services (article 16), mental health patients should be accorded special treatment in line with article 18(4) African Charter, concerning the protection of vulnerable groups, and found that the scheme of the LDA falls short in terms of therapeutic objectives and the provision of treatment of mental health patients. Important in that case was the African Commission declaring that despite being an important right, the implementation of the right to health in African countries has to be seen in light of underlying problems, such as poverty, and that a state's obligation is therefore to take 'concrete and targeted steps' towards a progressive implementation of the right according to available resources. Hence, it might not be crucial whether the right to health is fully implemented; what has to be assessed is whether states have taken necessary steps towards the provision of the right to health in line with their available resources. This interpretation significantly weakens the obligation imposed on states under article 16(2) African Charter, as it sparks the question of whether it enables states to avoid their obligations under article 16, blaming insufficient protection on a lack of available resources. Unfortunately, the African Commission does not specify the details of such exception to the state's general obligation under article 16. Notwithstanding, claiming that the steps taken by the Gambia were not sufficient, including the improvements of the nature of care given to mental health patients and the developments of a mental health law reform, the African Commission found a violation of article 16 in

14 Before the African Court on Human and Peoples' Rights, health has been addressed as part of the discussion about other human rights violations, see eg Application 6/2012, *African Commission on Human and Peoples' Rights v Kenya*; and Application 46/2016, *APDF & IHRDA v Mali*. Cases with alleged right to health violations were held inadmissible, see eg Application 40/2016, *Mariam Kouma & Another v Mali* (2018); and Application 42/2016, *Collectif des Anciens Travailleurs du Laboratoire ALS v Mali* (2019). Still on-going is case Application 12/2017, *Mugesera v Rwanda*, claiming a lack of medical attention during detention.

15 See eg Application 4/2013, *Lohé Issa Konaté v Burkina Faso* (Order of Provisional Measures) (2013).

16 See case-law of the ACHPR, eg Communication 155/96, *Social and Economic Rights Action Centre (SERAC) & Another v Nigeria*, Thirtieth Ordinary Session, paras 50-54; or Communication 379/09, *Monim Elgak & Others v The Sudan*, Fifteenth Extra Ordinary Session, paras 134-135; *Egyptian Initiative for Personal Rights and Interights v Egypt I* (2011) AHRLR 42 (ACHPR 2011), para 261.

connection with article 18(4) of the African Charter.¹⁷ Amongst other human rights violations, the claimants further allege that the conditions within the psychiatric jails amounted to cruel, inhumane and degrading treatment. By accepting that persons with mental disorders have a right to dignity and a life as full and normal as possible, the African Commission ruled that the provisions of the LDA amount to a violation of article 5 of the African Charter, the right to be free from cruel, inhumane and degrading treatment.¹⁸

While mental health is by definition part of the right to the best attainable state of physical and mental health, the preceding analysis shows that for the protection of persons within the mental healthcare system, the enjoyment of the right to mental health is closely connected to and might even depend on the enjoyment of other human rights. Scholars have argued that article 5 of the African Charter indirectly protects the right to health, or in other words, that a violation of article 5 within healthcare settings infringes on the right to health.¹⁹ When seeking treatment, it is particularly mental health patients who are more vulnerable to various forms of exploitation, violence and abuse.²⁰ Therefore, the following section examines the right to be free from inhumane and degrading treatment in connection to the right to mental health, namely when seeking mental healthcare.

2.2 The right to be free from inhumane and degrading treatment

The African Commission calls attention to violations against the right to dignity and freedom from inhumane and degrading treatment of persons with mental disorders in Africa, as it addresses that mental healthcare patients throughout the African region are subject to forced treatment without prior, free and informed consent given, forced sterilisation, beatings, chaining, food deprivation and forced detention.²¹ Article 5 of the African Charter provides that

[e]very individual shall have the right to the respect of the dignity inherent in a human being [...] All forms of exploitation and degradation of man, particularly [...] inhuman or degrading punishment and treatment shall be prohibited.²²

17 African Commission, *Purohit & Another v The Gambia* (2003) AHRLR 98 (ACHPR 2003), paras 80-84 (*Purohit* case).

18 n 17, paras 59-61.

19 Unpublished: MC Van den Bossche 'Protection of the right to health through the human rights discourse in Africa' unpublished Master thesis, Ghent University, 2014 https://lib.ugent.be/fulltxt/RUG01/002/163/014/RUG01-002163014_2014_0001_AC.pdf (accessed 14 June 2019).

20 K Hughes *et al* 'Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies' (2012) 379 (9826) *The Lancet* 1621.

21 African Commission, Resolution 343 on the Right to Dignity and Freedom from Torture or Ill-Treatment of Persons with Psychosocial Disabilities in Africa (20 April 2016).

22 Banjul Charter (n 5) art 5.

While there is no soft-law document to interpret article 5 in light of the mental healthcare context,²³ the earlier examined Protocol on Disability Rights can again be referred to. The Protocol recalls the provisions of article 5 of the African Charter, but also adds in its article 10 that states need to take appropriate and effective measures to ensure that persons with mental disabilities are protected. Furthermore, it defines that freedom from inhumane or degrading treatment or punishment includes not being subject to medical intervention, experimentation, sterilisation or other invasive procedures without free, prior and informed consent, and being protected against any form of exploitation, violence and abuse inside one's home and elsewhere.²⁴ The Protocol on Disability Rights further provides that states need to take specific measures to protect persons with mental disorders against such forms of ill-treatment, prosecute perpetrators of abuses, and provide remedies for victims. As supplement to article 5 of the African Charter, the article of the Protocol on Disability Rights is a milestone for the protection of persons with mental disorders against inhumane and degrading treatment within the African region.

As previously outlined, the African Commission also found a violation of article 5 of the African Charter in *Purohit & Another v The Gambia*. In that Communication, the African Commission draws from two other cases to explain the violation of article 5. In *Media Rights Agenda & Others v Nigeria*, the African Commission held that cruel, inhuman or degrading treatment and punishment 'is to be interpreted so as to extend to the widest possible protection against abuses, whether physical or mental', and that no circumstance may be invoked as justification for cruel, inhuman or degrading treatment or punishment.²⁵ In *John K Modise v Botswana*, the African Commission further argues that 'personal suffering and indignity', which can take many forms, amounts to a violation of article 5 of the African Charter.²⁶ In its conclusion in *Purohit & Another v The Gambia*, the African Commission refers to the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Care, which requires that 'all persons with mental illness, or who are being treated as such, shall be treated with humanity and respect for the inherent dignity of the human person'.²⁷ In conclusion thereof, any circumstance that denies any form of dignity or that dehumanises is in contravention of article 5 of the African Charter.

23 The 2008 Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in Africa (adopted in 2002, revised in 2008) do not refer to the mental healthcare context.

24 African Union (n 12) art 10.

25 African Commission, Communication 224/98, *Media Rights Agenda & Others v Nigeria*, Twenty-Eight Ordinary Session, paras 70-71.

26 African Commission, Communication 97/93, *John K Modise v Botswana*, Twenty-Eight Ordinary Session, para 92.

27 See ACHPR (n 17) para 60; and United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (17 December 1991) UN Doc A/RES/46/119.

3 GHANA'S LEGAL FRAMEWORK RELATING TO THE TREATMENT OF PERSONS WITHIN THE MENTAL HEALTHCARE SYSTEM

The African Charter establishes a regional framework for the promotion and protection of human rights within the African Union states. So how does Ghana domesticate the regulations of articles 5 and 16 African Charter for them to become justiciable human rights?

3.1 Constitutional protection

After becoming state parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR), many African states revised their constitutions.²⁸ Today, 33 percent of all national constitutions in Africa offer a comprehensive exposition of the right to health;²⁹ for instance the Constitutions of Kenya and South Africa, which provide the explicit right to the 'highest attainable standard of health, which includes the right to health care services',³⁰ or the right of everyone to have access to healthcare services,³¹ respectively. These constitutions guarantee the right as justiciable constitutional right vis-à-vis other constitutions that provide for the right to health as part of directive principles and objectives of state policy, thereby reducing its enforceability. The Constitution of Ghana is amongst those 15 percent of African constitutions,³² that lists 'the right to good healthcare' only as directive principle, not as fundamental human right.³³

However, the right to health is in some way justiciable in Ghana. The Supreme Court of Ghana determined in *Ghana Lotto Operators Association v Ghana Lottery Authority* that an article that falls under the directive principles is an enforceable right.³⁴ The Court held that in order to strengthen the legal status of economic, social and cultural rights, the justiciability of the directive principles has to be presumed. Under that observation, one could argue that the right to good healthcare is also justiciable. Furthermore, the Economic Community of West African States (ECOWAS) Community Court of Justice, a regional court with jurisdiction over human rights violations committed by an ECOWAS member state, found the following in

28 M Ssenyonjo 'The influence of the International Covenant on Economic, Social and Cultural Rights in Africa' (2017) 64 *Netherlands International Law Review* 259 at 269.

29 A le Roux-Kemp 'The recognition of health rights in constitutions on the African continent: a systematic review' (2016) 24 *African Journal of International and Comparative Law* 142 at 143.

30 The Constitution of Kenya, 2010, art 43.

31 The Constitution of the Republic of South Africa, 1996, sec 27(1)(a).

32 Le Roux-Kemp (n 29).

33 The Constitution of the Republic of Ghana, 1992, sec 34(2).

34 *Ghana Lotto Operators Association v National Lottery Authority* [2007-2008] SCGLR 1089.

SERAP v Nigeria: irrespective of a country's categorisation of rights as merely directive principles of state policy, rights protected in the African Charter are at least justiciable before the ECOWAS Court.³⁵ Lastly, while the right to health is not expressly guaranteed in the Constitution, it is worthwhile to refer to section 33(5), which indicates that courts should protect human rights that are considered to secure the dignity of a person, among others, even if not specifically mentioned under the fundamental human rights. This could be understood as obliging the state to protect the right to health, encompassing access to humane and dignified healthcare.

Since this article focuses on mental healthcare concomitant with exploitation, violence and abuse, and not purely on the right to health, it is important to examine the Constitution of Ghana in that regard. Indeed, the Constitution offers more protection as first anticipated. Section 15 sets forth that the dignity of every person is inviolable, and that no one should be subject to torture or other cruel, inhumane or degrading treatment or punishment, or other conditions that (are likely to) detract from the person's dignity and worth as a human being.³⁶ Moreover, the Constitution declares in section 29 that '[d]isabled persons shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature'.³⁷ Since it does not specify on physical disability only, it can be interpreted as to also be applicable for mental disability.

Consequently, the framework of the Constitution clearly protects persons with mental disorders and disabilities against exploitation, violence and abuse in the mental healthcare setting.

3.2 Protection under domestic legislation and policy

Legislation regarding mental healthcare delivery in Ghana has been in place for over 100 years. The first Act relating to mental health, the Lunatic Asylum Act 1888, marked the beginning of 'formal government mental health service delivery in Ghana'.³⁸ Under the Act, people who were suspected to suffer from mental disorders were confined in special institutions. With the passing of the Mental Health Decree of 1972 (NRCD 30), persons with mental disorders were not regarded anymore as special prisoners who need to be arrested, but as individuals who require treatment. Notwithstanding, Ghanaian chief psychiatrist Akwasi Osei announced that the Decree did not protect affected individuals against unnecessary abuse, as persons were still subjected to being locked away for decades and being seriously mistreated.³⁹

35 *SERAP v Nigeria*, Judgment, Court of Justice of the Economic Community of West African States (27 October 2009) ECW/CCJ/APP/0808, paras 14 & 19.

36 Constitution of the Republic of Ghana (n 33) sec 15.

37 n 33 above, sec 29(4).

38 S Adu-Gyamfi 'Mental health service in Ghana: a review of the case' (2017) 6 *International Journal of Public Health Science* 299.

39 A Osei *et al* 'The new Ghana Mental Health Bill' (2011) 8 *International Psychiatry* 8.

It was not until recently that domestic legislation explicitly started protecting persons with mental disorders against exploitation, violence and abuse. The Persons with Disability Act 715 of 2006 states that '[a] person shall not discriminate against, exploit or subject a person with disability to abusive or degrading treatment'.⁴⁰ Despite the reference to discrimination, scholars have criticised that provision and pointed out an omission of the Act that gives room to exploitation.⁴¹ They find that the Act should contain a general non-discrimination clause. While it is acknowledged that the Act provides for persons with disability to not be discriminated against or exploited on grounds of their disability, critics propose that the non-discrimination provision of the Act is not comprehensive enough to address all forms of discrimination, as it focused on direct discrimination only. In other words, the Act fails to address indirect discrimination, including attitudinal, institutional and environmental barriers, which ultimately affects the treatment of persons with mental health issues and whether or not they are subject to exploitation, violence and abuse within mental healthcare institutions.⁴²

Furthermore, the Executive Director of the National Council of Persons with Disabilities (NCPD) disclosed in an interview that since the enactment of the new Mental Health Act and the establishment of a Mental Health Authority as overseeing body, the NCPD does not find itself responsible anymore for programs and interventions for persons with mental health issues. The Executive Director agrees that the Disability Act protects persons with mental disabilities, but the Act only protects their general rights and for specific rights, one has to draw from the new mental health law.⁴³ Although that perception of responsibility does not amount to insufficient protection for persons with mental disabilities *per se*, since the mental health law grants protection, the reservation of the NCPD as main body governing disability rights in Ghana can nevertheless be seen critical for the human rights protection of affected individuals.

The passing of the Mental Health Act 846 of 2012 started a new era of protecting the human rights of persons with mental disorders and has to be seen as significant breakthrough in regard to addressing mental health as a public health issue.⁴⁴ The WHO calls the Act 'a very progressive mental health law',⁴⁵ which can 'serve as a model for other African countries wishing to develop progressive mental health laws

40 Republic of Ghana, Person with Disability Act 715 of 2006, art 3, sec 4(1).

41 See eg EA Gyamfi 'Country report on Ghana' (2013) 1 *African Disability Rights Yearbook* 221; and L Asante Abedi & A Sasu 'The Persons with Disability Act, 2006 (Act 715) of the Republic of Ghana: the law, omissions and recommendations' (2015) 36 *Journal of Law, Policy and Globalization* 62 at 64.

42 J Ocran 'Exposing the protected: Ghana's disability laws and the rights of disabled people' (2018) 34 *Disability & Society* 663 at 666.

43 Executive Director of the Ghana National Council of Persons with Disabilities, personal interview (21 May 2018).

44 Republic of Ghana, Mental Health Act 846 of 2012.

45 WHO 'Ghana: a very progressive mental health law' https://www.who.int/mental_health/policy/country/GhanaCountrySummary_Oct2007.pdf (accessed 16 January 2019).

that respect international human rights standards'.⁴⁶ The Act reflects international human rights and best practice standards, and considers local conditions, requirements and customs. The law takes into account the significant role of traditional and faith-based healers, and acknowledges and regulates informal mental health facilities in order to safeguard against inhumane and degrading practices. Section 57 of the Act defines the right to the highest attainable standard of mental healthcare for persons with mental disorders and states that they are

entitled to the same standard of care as a person with physical health problems and [treatment] on an equitable basis including quality of in-patient food, bedding, sanitation, buildings, levels and qualifications of staff, medical and related services and access to essential medicines.⁴⁷

Moreover, the section provides that service users in both conventional and traditional mental healthcare institutions should not be subject to cruelty, torture or any other form of inhumane treatment.⁴⁸ This regulation is supported by what is outlined as a basic human right in section 55, namely that persons with mental disorders are at any time entitled to humane and dignified treatment with respect to their personal dignity and privacy.

Notwithstanding these provisions, let us look at previously examined important elements of being free from ill-treatment within the mental healthcare provision, for instance respecting the choice over one's body, not being chained or forcefully detained, or informed consent. Section 58 allows for seclusion and restraint to some extent by outlining that involuntary seclusion or minimal mechanical restraints can be placed on a person 'when there is imminent danger to the patient or others and tranquilisation is not appropriate or not readily available'.⁴⁹ Although it is further written that 'seclusion or restraint [...] shall not be used as punishment or for the convenience of staff',⁵⁰ it undoubtedly opens the door for possible abuses justified by vague explanations, especially when argued that needed tranquilisation was not available or simply not appropriate to the level of risk posed by the situation. The Act also addresses informed consent in detail. For instance, a voluntary patient has to give consent before a treatment is given which comes with the right to refuse treatment.⁵¹ However, it also allows for temporary involuntary admission and treatment under recommendation if persons are believed to be risk to themselves or other people, or if there is a substantial risk of a serious deterioration of the mental disorder. In those instances, the environment has to be as least restrictive as compatible with the health and safety of the person and society.⁵² It specifically prohibits major medical procedures without informed consent; nevertheless, it allows that a personal

46 https://www.who.int/mental_health/policy/country/ghana/en/ (accessed 15 January 2019).

47 Mental Health Act (n 44) sec 57(2).

48 Mental Health Act (n 44) sec 57(3).

49 Mental Health Act (n 44) sec 58(1).

50 Mental Health Act (n 44) sec 58(4).

51 Mental Health Act (n 44) sec 40.

52 Mental Health Act (n 44) sec 42.

representative can give consent to that if the patient is incapable to do so.⁵³ Until now, many provisions of the Act remain unimplemented for reasons like a missing Legislative Instrument and important structures that are still not operational.

In 2018, the Ministry of Health published the Ten Year Mental Health Policy 2018-2027,⁵⁴ to guide the implementation of the Act and the establishment of the Mental Health Tribunal and Visiting Committees, two essential mechanisms under the Mental Health Authority for the human rights protection and promotion in line with the Act. At this point, the composition of these mechanisms is noteworthy: the Tribunal is composed of members with legal, psychiatry, psychology and social service backgrounds, as well as service users; and the Visiting Committees consist of regional representatives from health management teams, social services, and the council, as well as non-local mental health professionals and legal practitioners. Bringing together different backgrounds and regional as well as non-local members can be seen as strong joint effort to assist the effective implementation of the Act. However, it can simultaneously impede the implementation because of existing conflicts of interests between the members.

One of the guiding principles of the Policy is to uphold the dignity and autonomy of persons with mental disorders and to ensure freedom from any form of discrimination. Amongst the Policy objectives is the implementation of strategies to protect, promote and ensure the human rights of persons with mental health conditions. Stating that the greatest challenge of mental healthcare in Ghana is in the area of human rights abuses, the Policy aims at guaranteeing the rights of persons with mental health conditions, strengthening the Mental Health Tribunal and Visiting Committees for human rights protection, engaging traditional and faith-based healers to respect the rights of persons with mental health conditions under their care, and enforcing the ban of all human rights abuses, including chaining, shackling, caging, and forced fasting. The Policy states that collaboration between the ministries and agencies, NGOs, traditional rulers and civil society is needed for ensuring that persons with mental disorders are free from abuse. Despite referring to various stakeholders as responsible actors for the human rights protection, it lacks detailed specific roles of the stakeholders and declares that such details will be established in due course. Moreover, besides pointing out the importance of the Visiting Committee and the Mental Health Tribunal, the Policy does not set out to explain how these institutions have to be established and operated. While the Policy is portrait as a document that supports the implementation of the Act and foster the human rights protection of persons with mental disorders, it can be criticised for not offering precise regulations and strategies from which clear actions and responsibilities could be derived.

53 Mental Health Act (n 44) sec 71.

54 Ministry of Health, Ghana, Ten Year Mental Health Policy 2018-2027.

More regulations about protecting affected individuals against ill-treatment can be found in guidelines launched in 2018. The Guidelines for Traditional and Faith-Based Centres in Mental Health Care provide that such institutions should ensure the freedom from exploitation, and from cruel, inhumane and degrading treatment, including flogging, chaining, shackling, roping or caging. If there is a need to restrain an aggressive or violent person who has been involuntarily admitted because of an emergency situation, a soft cloth can be used to restrain, but the person then has to be transferred to a conventional mental health facility within forty-eight hours.⁵⁵ However, there is no guideline addressing and regulating human rights abuses in the conventional mental healthcare sector where, as demonstrated in the next chapter, ill-treatment takes place as well.

4 THE PRACTICE OF MENTAL HEALTHCARE IN GHANA

Since the inauguration of Ghana's Mental Health Authority (MHA) in 2013, measures have been taken to protect persons with mental disorders against exploitation, violence and abuse. The MHA has organised public education and advocacy campaigns to reduce stigma and discrimination. NGOs, but also the MHA together with the Ghana Federation of Traditional Medicine Practitioners Associations, have trained traditional and faith-based healers throughout the country to reduce human rights violations against persons with mental health conditions. Additionally, the MHA formally banned chaining and shackling of persons with mental illness in October 2017. The newly launched guidelines for the operation of traditional and faith-based healing centres, covering various aspects of human rights, also aim at protecting persons with mental disorders from ill-treatment.⁵⁶ In spite of this progress, challenges remain in the conventional and traditional service provision. Pascale notes that state practice of implementing the right to quality (mental) healthcare is inconsistent throughout the African region and argues that the reasons why states do not fully fulfil their obligations include the acute shortage of financial, institutional and human resources within the mental healthcare system.⁵⁷

4.1 Situations amounting to ill-treatment

The Committee for the Prevention of Torture in Africa reported that in Ghana, persons with mental disorders often continue to live against

55 Mental Health Authority, Ghana, Guidelines for Traditional and Faith-Based Centres in Mental Health Care, 2018, p 7.

56 As above.

57 G Pascale 'The human right to health under the African Charter on Human and Peoples' Rights: an evaluation of its effectiveness' (2016) 22 *Federalismi.it Journal* 2 11-12.

their will in psychiatric hospitals and traditional facilities, with little or no possibility to challenge their confinement.⁵⁸ Although the inhumane practices in traditional settings have been more in the spotlight, the ongoing ill-treatment in conventional mental healthcare institutions cannot be neglected. Juan Méndez, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, found that Ghana's public psychiatric facilities lacked qualified staff and equipment, had poor sanitation, were overcrowded, applied electroshock therapy administered with the use of restraints, without adequate anesthesia and not as a last resort, and had a lack of psychoactive drugs which leads to inadequate treatment of persons.⁵⁹ The psychiatric hospitals were generally underfunded, causing a lack of essential medication provision, which requires persons to buy their own, usually very expensive, medicine, and there was a serious shortage of not just facilities where persons with mental health conditions could turn to, but also psychiatrists. Although Méndez reviewed hospital files documenting the consent of service users, he doubted that the consent is truly free and informed in practice.⁶⁰ The MHA 2017 Annual Report states that in a client satisfaction survey, persons in psychiatric hospitals were 'largely satisfied [with the quality of service], mindful of constraints facing the hospital',⁶¹ but the question is whether this reflects the opinion of all admitted persons. Further, the same report shows that the initiative of sending home persons who had been abandoned at the hospital and who were kept against their will was stalled due to lack of funds. In reality, many of the outlined challenges remain up to date.⁶² The MHA addresses this only briefly in its Annual Report by including in its Activity Plan the need to identify and train human rights officers for the psychiatric hospitals.⁶³

The implication of the law on conventional mental healthcare is clear, but how can it be converted into practice? Former executive director of one of the psychiatric hospitals disclosed in an interview that the Mental Health Act still receives too little attention in general. The former director sees the stigma that exists also among policy-makers and missing funding as main drivers for the delaying implementation of the Act, and thus for actual change. When examining the issue of involuntary admission and treatment, it was said that in practice, a person might not agree to be admitted and treated. There might not be

58 Committee for the Prevention of Torture in Africa 'Intersession Activity Report' <http://www.achpr.org/sessions/55th/intersession-activity-reports/cpta/> (accessed 15 July 2019).

59 This article refers to public psychiatric facilities and does not examine private psychiatric facilities and services, for example offered through the Christian Health Association of Ghana.

60 UNGA 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, Mission to Ghana' (5 March 2014) UN Doc A/HRC/25/60/Add.1, paras 68-71.

61 Mental Health Authority, Ghana, Annual Report of 2017, 47.

62 See Ministry of Health (n 54); or Human Rights Watch (HRW) 'Ghana should implement commitments on mental health issues' 15 March 2018 <https://www.hrw.org/news/2018/03/15/ghana-should-implement-commitments-mental-health-issues> (accessed 18 July 2019).

63 Mental Health Authority (n 61) 73.

enough visible reasons for the practitioner to allow for involuntary admission, but the family has observed the deterioration and danger the person poses. According to the new law, the family has to get two opinions of doctors and a court order that confirms involuntary admission. But still, persons end up in the psychiatric hospitals without such court order and practitioners have to make a decision on what to do. When having fifty or more persons waiting, there is too little time to do proper examination and diagnoses. Hence, very often, due to the lack of human resources, practitioners are forced to make a fast decision in regard to involuntary admission for observation, and then the question is whether treatment should be started. The interviewee agreed that the Mental Health Act is important and the regulations are ideal, but that the on-going practices in the psychiatric hospitals, which may be unlawful, are a product of missing resources, starting with financial resources, and thus practitioners cannot be blamed for what is being done.⁶⁴

In traditional mental healthcare facilities, ill-treatment has been recorded in different forms: being chained or shackled, starved in the name of fasting, deprived of water, flogged or used for forced labour, forced to take herbal concoctions against the person's will, or being sexually harassed or abused.⁶⁵ Mental health service users often do not receive adequate medical treatment and despite the ban of chaining and shackling, it is a procedure still carried out widely.⁶⁶ While some traditional or faith-based healers claim that they no longer shackle persons, some confessed that they have simply moved the persons shackled off the facility's premises so that officials could not find them.⁶⁷ The MHA's human rights activities to end inhumane and degrading treatment have mostly targeted the informal or traditional sector. Indeed, the traditional mental healthcare practices seem to pose many challenges for being free from ill-treatment. Most of these challenges are based on spiritual implications surrounding illness; for example that herbal drinks, which persons are forced to take, contain spiritual healing powers, or that forced fasting is a key component for curing mental disorders as it starves the evil spirits and 'allows the spirit of God to heal'.⁶⁸ Traditional practitioners have described such restrictions as necessary for a holistic and effective healing process.⁶⁹

When assessing ill-treatment in traditional mental healthcare facilities, it is possible that there is a need to look beyond the right to be

64 Former Director of Pantang Psychiatric Hospital, personal interview (4 May 2018).

65 See Ministry of Health (n 54); or Committee for the Prevention of Torture in Africa (n 58).

66 HRW 'Ghana: oversight needed to enforce shackling ban' 9 October 2018 <https://www.hrw.org/news/2018/10/09/ghana-oversight-needed-enforce-shackling-ban> (accessed 18 July 2019).

67 Investigated during visits to traditional mental health facilities together with a representative of the Ghana Association of Faith Healers throughout the Greater Accra, Central and Volta Region in Ghana in 2018.

68 UNGA (n 60) para 77.

69 LNA Kpobi *et al* 'Traditional herbalists' methods of treating mental disorders in Ghana' (2018) *Transcultural Psychiatry* 250 259.

free from degrading or inhumane treatment when receiving mental healthcare; could the right to religion or the right to assembly prevail? Especially if affected individuals freely choose to obtain traditional healthcare, do the inhumane or degrading treatment methods really amount to a violation of their right to be free from exploitation, violence and abuse? Or in other words: is it possible to give consent to what can be seen as ill-treatment? Instead of simply classifying some traditional mental healthcare methods as violating the human right of affected persons, it is important to keep in mind that some individuals choose or prefer traditional healthcare over conventional healthcare.

Despite that, the implications of the law, both regional and domestic, seem clear: when carried out in a non-abusive or non-degrading way according to legal standards, traditional mental healthcare is an accepted form of mental healthcare. The way forward could be, and this is supported by the MHA, to ensure that traditional practices, no matter if it includes herbal or spiritual methods, adhere to the law. Even if that means that certain practices have to be discontinued, such as forced fasting, and even if that sparks the question of infringing upon someone's right to freedom of religion or assembly. After all, freedom of religion and assembly are not absolute rights and thus, may be limited on grounds justified under human rights law.

In February 2019, the WHO and MHA launched the QualityRights initiative in Ghana, a programme that aims at training 50,000 people to ensure respect for human rights and to improve the quality of mental healthcare in conventional and traditional mental healthcare facilities.⁷⁰ Although this programme is a step forward, it should not overshadow the need to make active changes towards the implementation of the law. After all, the delay in the establishment of the Visiting Committee has made the monitoring of exploitation, violence and abuse in conventional and traditional mental healthcare facilities virtually impracticable. Moreover, besides the monitoring, legal aid to claim one's right also plays a critical role.

4.2 Legal and judicial challenge

Additional to legislation, a legal forum needs to be available where persons can go and seek redress for the breach of their human rights, and where professionals assist persons in their representation; otherwise the protection of human rights is at stake. Despite the wide knowledge of existing human rights abuses, no complaint has been brought before the domestic court yet, neither has a Ghanaian case in that regard been before a regional judicial instance. According to the Mental Health Act, the establishment of a Mental Health Tribunal under the MHA, quasi-judiciary in nature, would bring more attention and more justice to human rights violations of persons with mental

70 HRW 'Not everyone is celebrating on Independence Day in Ghana' 13 March 2019 <https://www.hrw.org/news/2019/03/13/not-everyone-celebrating-independence-day-ghana> (accessed 19 July 2019).

disorders. The functions of the Tribunal will be, *inter alia*, (i) reviewing and monitoring cases of involuntary admissions and treatment processes, and long-term stay voluntary admissions, (ii) providing guidance on minimising intrusive and irreversible treatments, seclusion or restraint, and (iii) hearing and investigating complaints in respect of persons detained in mental healthcare facilities.⁷¹ It can be understood that the Tribunal will not only investigate after complaints are filed, but that it will have a more active monitoring role. However, what can be criticised is that the functions look at protecting cases of which the Tribunal already knows of, for example through court orders, or whenever service users or their relatives or caregivers make an appeal to the Tribunal. Moreover, the Mental Health Act does not grant NGOs or other civil society organisations the right to make a complaint to the Tribunal.⁷² Hence, the problem remains with cases that will stay unmentioned to the court. While it is amongst the duty of the Visiting Committee to receive and enquire into complaints,⁷³ the law is not clear about whether complaints will be forwarded to a judiciary instance on behalf of the persons whose rights were infringed.

Some scholars argue that the Commission for Human Rights and Administrative Justice (CHRAJ) is the *de facto* Mental Health Review Tribunal.⁷⁴ CHRAJ has a mandate to protect and promote human rights, and its functions include (i) receiving and investigating complaints from and on behalf of persons suffering from mental ill-health concerning practices and actions by persons or institutions where those complaints allege violations of fundamental rights and freedoms, and (ii) taking appropriate action to call for remedy.⁷⁵ Moreover, CHRAJ is supposed to '[carry] out special investigations into human rights abuses that are systemic or cultural [and investigate] other human rights violations brought to the Commission's attention'.⁷⁶ It could be concluded that even if no complaint is filed, CHRAJ should carry out special investigations because the matter of ill-treatment in mental healthcare facilities is known. In 2009 and 2010, CHRAJ set out to monitor traditional mental healthcare facilities and published its concerns and recommendations in reports. Nevertheless, the Director of Human Rights at CHRAJ stated in an interview that unless affected individuals reach out to CHRAJ with a human rights complaint, the organisation does not take action towards remedy, and rather calls upon civil society to intervene and speak on behalf of the vulnerable group.⁷⁷ While it is the responsibility of the state to protect persons with mental disorders against human rights abuses, it can be

71 Mental Health Act (n 44) sees 26(1), (2) & (5).

72 With the exception of the right to appeal against a decision of continuous guardianship, see Mental Health Act (n 44) sec 70(2).

73 Mental Health Act (n 44) sees 36(1)(c) & (37).

74 See eg Adu-Gyamfi (n 38) 304.

75 The Republic of Ghana, Commission of Human Rights Act 456 of 1993, sec 7.

76 <https://chraj.gov.gh/human-rights/> (accessed 30 July 2018).

77 Director of Human Rights at Commission on Human Rights and Administrative Justice, personal interview (10 May 2018).

seen as fundamental role of civil society to promote their human rights protection, especially if a state does not fulfil its obligations.

5 CONCLUSIONS

The domestication of articles 5 and 16 of the African Charter has come a long way in Ghana's legal framework. Today, there is a comprehensive human rights framework that protects persons against exploitation, violence and abuse in the mental healthcare system in Ghana. To conclude this paper, the last chapter analyses gaps and shortcomings of the regional and domestic law, followed by recommendations for possible developments to overcome persisting hurdles.

5.1 Uncovering gaps and shortcomings

To complete the normative analysis, I draw attention to prevalent gaps between the regional and domestic legislation and consider whether the analysed legal frameworks, both regional and domestic, fall short in regard to protecting persons with mental disorders against exploitation, violence and abuse.

Firstly, I compare the two systems. From the regional human rights law, it can be summed up that persons with mental disorders have a right to access humane and dignified care to minimise or prevent further mental disability while having control over their body and health, being free from unwarranted interferences, and if necessary, while being supported in decision making. The African Commission even defines access to humane and dignified care and treatment as minimum core obligation of states under the right to health. Regarding the freedom from inhumane and degrading treatment within the African human rights framework, the interpretation of the right seems straight forward: the care or treatment in the mental healthcare service provision can under no circumstance deny any form of dignity, nor dehumanise the affected individual, and nothing justifies such act.

When turning to the domestic legal framework, it is noticeable that it lacks a sufficient right to health norm. Ghana's Constitution does not expressly provide an enforceable right to health, with due consideration of the import of section 33(5), and the Disability Act only urges for providing free general and specialist care.⁷⁸ However, the Mental Health Act lists under basic human rights specific rights relating to treatment, including that persons with mental disorders have the right to the highest attainable standard of mental healthcare, and that affected individuals are entitled to humane and dignified treatment. Furthermore, the Act regulates informed consent, a topic formerly defined under the regional right to health norm, in regard to lack of mental capacity. Yet, it needs to be noted that the Act does not provide for supported decision making but calls for substituted decision making

78 Disability Act (n 40) sec 31.

by a guardian, a regulation that is criticised for undermining the will of affected individuals. Despite regulating what can be labelled as ‘the quality of treatment’, the Act lacks the positive right of persons with mental disorders to available, accessible, and affordable mental health facilities, goods, and services,⁷⁹ as provided within the regional system. In regard to the freedom from exploitation, violence and abuse, all three examined domestic laws protect against abusive or degrading treatment of persons within mental healthcare facilities. However, which leads to the following critical analysis of limitations to the rights under discussion, the Mental Health Act, in contrast to the regional human rights law, explicitly allows for derogation in what could be said being the freedom from ill-treatment, namely giving way to involuntary seclusion and minimal mechanical restraints.

Secondly, I want to discuss the existing limitations, how they differ between the regional and domestic law, and how such limitations could be a threat to the protection of persons with mental disorders against exploitation, violence and abuse. The only valid limitation pointed out in this article within the regional human rights law is that the fulfilment of the state obligations under the right to health is dependent on the resources available. As critically outlined above, this could inhibit the enforcement of the right, especially because states could argue to be incapable to fulfil their obligation to provide access to humane and dignified care because of limited available resources. Despite resource constraints, the African Commission obliges states to take concrete and targeted steps to ensure the realisation of the right. However, details as to what steps must be taken are not specified, which can be seen as a shortcoming within the regional human rights framework.

Moreover, it is unmentioned whether and how the limitation affects the previously determined minimum core obligation. The domestic cases of *Minister of Health & Others v Treatment Action Campaign or Government of the Republic of South Africa & Others v Grootboom & Others* are examples that show that the Constitutional Court of an African country, namely South Africa, has argued that in light of the fact that the ICESCR framework stipulates that states are obliged to promote the right to health within the state’s available resources, not even a minimum core obligation to provide the right to health can be imposed on the state.⁸⁰ In effect, the scope of this limitation cannot really be estimated since the extent of what concrete and targeted steps need to be taken, and whether or which minimum core obligations remain, is unclear.

In the domestic legislation, the Mental Health Act justifies more limitations to the right to being free from exploitation, violence and abuse within the mental healthcare system. Plausible reasons could be that the domestic law needs to apply to real situations, for example it

79 Section 2(d) of the Mental Health Act (n 44) merely lists as one of the objectives of the MHA to ‘promote a culturally appropriate, affordable, accessible and equitably distributed, integrated and specialised mental health care’.

80 See *Minister of Health & Others v Treatment Action Campaign* 2002 10 BCLR 1033 (CC), paras 23-39; and *Government of the Republic of South Africa & Others v Grootboom & Others* 2000 11 BCLR 1169 (CC), paras 27-33.

regulates what exactly can be done if persons with mental disorders become aggressive or create dangerous situations for themselves or others. However, notably, the Mental Health Act explains the application and scope of the limitations in detail. Here, a lack of resources does not justify the limitation of providing quality mental healthcare. Ghana's law is precise in when exceptional measures, such as restraint or involuntary admission and treatment, cannot be used, for example as punishment or for convenience reasons, and it further regulates under which circumstances the measures can be taken, for example applying restraint if there is a risk to the affected person or other persons, or allowing temporary involuntary admission and treatment only upon recommendation by specialists and through court order. By doing so, the law tries to minimise limitations of the human rights law, which can be viewed as positive. Nevertheless, I contend that any deviation from the right that needs to be protected, such as applying restraint or admitting and treating persons without granting them control over their body, even if justified by law, facilitates possibilities for ill-treatment. Naturally, real-life situations may demand such restrictions of the right, but it needs to be pointed out that with any restriction of a human right, the protection and enjoyment thereof may be weakened.

Lastly, although the Mental Health Act addresses ill-treatment in mental healthcare institutions and protects persons against exploitation, violence and abuse, I argue that the domestic framework falls short in suggesting alternative measures to restraint or involuntary treatment in order to eliminate exploitation, violence and abuse in the mental healthcare setting. While there is a guideline that specifically regulates restraint measures in traditional and faith-based institutions, a more comprehensive document that also applies to the conventional healthcare practice is missing.

5.2 Recommendations

The domestication of the regional human rights in Ghana's Constitution, the Disability Act and especially the Mental Health Act, has led to a new mental health policy and several guidelines, which are likely to contribute immensely to the protection against ill-treatment in the mental healthcare system. For that reason, it is not wrong to say that Ghana can be seen as a good example in that respect. Given the broad challenges that remain, however, I conclude this article with some recommendations.

First of all, there should be a dedicated institution that actively controls and supervises the mental healthcare practice in conventional and traditional institutions. Since this falls within the mandate of the MHA, the MHA could possibly appoint human rights institutions to carry out that task. Only with continuous and focused attention on inhumane and degrading practices can exploitation, violence and abuse be broadly limited and ultimately eliminated.

Second, seclusion and restraint, carried out only when there is a risk of harm to the person or others, has to be regulated better in a

policy in regard to time limits and measures used. Additionally, alternative methods should be suggested and how they can be applied, such as one-to-one verbal dialogue followed by pastoral care, or training staff on de-escalation and crisis management.⁸¹

Third, non-consensual treatment, such as forced medication or electroshock procedures in hospitals, has to be prohibited, and in severe situations where a person is incapable of providing consent, treatment decisions must be based on the best interpretation of the will and preferences of the person. Additionally, essential medicines need to be available for treating persons, even in traditional healthcare facilities.⁸² That demonstrates that collaboration between the conventional and traditional sector is important. Some traditional facilities in Ghana already cooperate with district hospitals, where community psychiatric nurses are called to administer sedatives and supply persons with medicine while they stay in traditional facilities. But in order to broadly tackle human rights abuses in the traditional sector, the collaboration between conventional and traditional mental healthcare providers needs to be strengthened further, something the WHO also calls for.⁸³ Informal mental healthcare similar to the Ghanaian example is carried out in many African countries,⁸⁴ and some countries have launched successful programmes to strengthen collaboration and improve the human rights protection. In Kenya, for example, projects in 2008-2009 and 2015-2016 showed that through task shifting between the formal and informal healthcare providers and community health volunteers, more persons received access to quality mental healthcare. The project activities included the training and capacity building of formal and informal health workers in (i) screening, identification and referral for traditional practitioners, and (ii) in detection and providing interventions of mental health disorders for formal general healthcare providers. That increased the number of referrals and the number of non-specialist health workers who are able to identify, diagnose and manage mental disorders.⁸⁵ A programme successfully carried out in Uganda firstly in 2012-2013, has shown that peer support groups also prove helpful to increase the

81 See eg BN Raveesh *et al* 'Alternatives to use of restraint: a path toward humanistic care' (2019) 61 *Indian Journal of Psychiatry* 693.

82 UNGA (n 60) paras 104(g), 105(a), (b), (c), (e) & (f).

83 WHO, Mental Health Action Plan 2013-2020; and WHO, Traditional Medicine Strategy 2014-2023.

84 See eg KG Mzimkulu & LC Simbayi 'Perspectives and practices of Xhosa-speaking African traditional healers when managing psychosis' (2006) 53 *International Journal of Disability, Development and Education* 417; A Gari *et al* 'Knowledge, attitude, practice and management of traditional medicine among people of Burka Jato Kebele, West Ethiopia' (2015) 7 *Journal of Pharmacy & Bio-allied Sciences* 136; or L Kajawu *et al* 'What do African traditional medical practitioners do in the treatment of mental disorders in Zimbabwe?' (2016) 9 *International Journal of Culture and Mental Health* 44.

85 Africa Mental Health Foundation 'Multi-sectoral Stakeholder TEAM Approach to Scale-Up Community Mental Health in Kenya' (December 2016); and VN Mutiso *et al* 'A step-wise community engagement and capacity building model prior to implementation of mhGAP-IG in a low- and middle-income country: a case study of Makeni County, Kenya' (2018) 12 *International Journal of Mental Health Systems* 1.

number of persons reaching out to mental health hospitals to receive adequate care.⁸⁶ Nevertheless, it should not be forgotten that ill-treatment does not only take place in the traditional mental healthcare system, but also the conventional. If more mental health professionals were recruited, for instance through educational scholarships, a higher level of care in conventional facilities could be delivered, and collaboration with and visits of qualified medical staff in traditional mental healthcare facilities could be scaled up.

Furthermore, training mental health workers on the rights of patients remains crucial for minimising human rights abuses. Although the newly launched QualityRights training aims at creating services free from exploitation, violence and abuse, the training is mostly internet-based and in English. Therefore, it is important that organisations, some of them having been active for years, keep on undertaking trainings in traditional and conventional settings, especially in rural areas where access to internet might be aggravated and where English may be an obstacle.

Ultimately, in order to support the promotion and protection of the respective human rights of persons in mental healthcare institutions, the government of Ghana has to actively provide access to legal aid, especially to persons who were admitted or treated involuntarily. Cases of alleged inhumane practices have to be thoroughly investigated and prosecuted under criminal law.

86 C Hall *et al* 'Brain gain in Uganda: a case study of peer working as an adjunct to statutory mental health care in a low-income country' in RG White *et al* (eds) *The Palgrave handbook of sociocultural perspectives on global mental health* (2017) 633.