DALARNA UNIVERSITY
CENTRE FOR
AFRICAN STUDIES

DALARNA
UNIVERSITY

Degree Project

Level: master's

The Ideology of Mental Illness in Ghana

A Discourse Analysis of Mental Health Laws (1972-2012)

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Subject/main field of study: Critical Discourse Analysis/Medical Anthropology
Course code: AS3013
Credits: 15
Date of examination: 2018/06/18

Abstract

In 2012, Ghanaian government promulgated a new mental health law aimed at setting up a community-based health care system in order to solve several problems that are affecting mental health facilities and people with mental disorders. The new law was also thought to overcome the limitations of the previous law, which was promulgated in 1972.
This study provides an analysis of the mental health laws promulgated by the government of Ghana from 1972 to 2012. Through the methodological tools offered by Critical Discourse Analysis (CDA), the aim of the thesis is to trace the ideological background of mental health laws and its changes over time. The analysis is particularly focused on themes such as the issue of public safety, the construction of the "mentally ill subject" and the conceptualisation of mental illness in the legal texts.

Keywords

Critical Discourse Analysis, Ghana, Ideology, Law, Mental health, Mental health policies, Mental health services, Mental illness, Public safety, Subjectivity

Anything beyond this, the teacher's directives apply.

CONTENTS

CHAPTER I
INTRODUCTION

Background

Africa has to face a huge number of public health problems: from malnutrition to sexually transmitted diseases and others. The impact and the costs of such issues overshadow other causes of illness and death, like mental disorders. However, measures in Disability-Adjusted Life Year (DALY – a measure expressed as the number of years lost due to ill-health) shows that mental illness has a greater impact on people's lives compared to other diseases such as tuberculosis, cancer and heart disease (Alem, 2000). In Africa, mental disorders are as prevalent as in the other continents. Yet, they are not considered a priority. African states invest just a negligible part of their healthcare budget in providing care, assistance and infrastructure to people with psychosocial disorders and their families. On average, only the 0.62% of health expenditure is allocated for mental health care; only 56% of the African countries have a mental health service and there is a huge shortage of skilled mental health workers (Alem & Manning, 2016:303-304). Furthermore, there is a legislative gap on mental health issues, so that abuses on mentally ill people are not legally prevented. Some countries do not have a mental health legislation at all.

Given this huge lack of services and appropriate legislation, people with psychosocial disorders are vulnerable to several forms of coercion, violence and human rights abuses at large. These abuses can appear at different levels of society. First, research shows that people with mental disorders can be object of physical restraint and violence in their own home (Alem & Manning, 2016:307). Sometimes the patient can indeed represent a heavy burden for the family, not only for the costs of the healthcare, but also for the mockery and for the stigmatization they receive from the broader community. Hence, families who lack the resources to cope with the case, often keep the person under restraint at home, sometimes shackled, waiting until the patient will not be dangerous or will not be object of derision for the household anymore. But human rights abuses can be also committed

by the health care services themselves. Mental health workers often receive an inadequate training and adopt stigmatizing and discriminatory behaviours toward their patients. Moreover, many African people resort to traditional or faith healers to heal mental disorders. The healers often confine the patients for large periods of time, during which they are submitted to several forms of maltreatments and torture, like prolonged shackling, beatings and forced fasting (Alem & Manning, 2016:309).

In this scenario, the Ghanaian case is no exception. As we will see in chapter 2, the country has to face a lot of challenges in order to provide adequate mental health services. Among these, there are problems in financing mental health facilities, in the organizational structure, in the recruitment and formation of psychiatric personnel and the appeal of traditional and religious leaders for the population. However, in the last decade there have been signals of change. In 2012 the Ghanaian government took some step toward the amelioration of the situation of people with psychosocial disorders by promulgating a new Mental Health Act (Act No. 846, 2012) designed to establish the policy framework of the national mental healthcare system. In particular, the new provision seeks to deliver health services to people with mental disorders in a community-based and human rights perspective (Walker & Osei, 2017:38). The new law has replaced the Mental Health Decree (NRCD No. 30, 1972) forty years after its enactment. The old law was more concerned with the administration of hospitals. In any case, the Decree has never been implemented in the field (Doku et al., 2012:241).

In this study, we will see how and to what extent the new law differs for the previous one and how both the enactments are ideologically and morally situated. The findings can help to foresee what might be the pragmatic outcomes of the particular ideology of mental illness as showed in the legislative texts.

Objective

The objective of this thesis is to examine the development and the changes in the ideology of mental illness in the policy discourse in Ghana. Through a qualitative analysis of the content of national legal documents, the thesis aims to bring out (1) how the specific regulations concerning mental health facilities are justified in the legal texts; (2) which categories the laws use to subjectify people with mental disorders and (3) how mental

illness is understood in the texts. The research will identify the changes and the developments that occurred from the promulgation of the first law in 1972 to the second one in 2012.

Research questions

- How are regulations of mental health services justified in Ghanaian mental health laws?
- Who is the mentally ill subject?
- What is mental illness, as conceived in legal texts?
- How has the ideology of mental illness changed from 1972 to 2012?

Primary Sources

The primary sources analysed in this study are the two legislative texts promulgated by Ghanaian government:

- Ministry of Health (1972). *Mental Health Decree*
- Ministry of Health (2012). *Mental Health Act*

I decided to take in consideration only the documents published by the government after the independence of Ghana. The colonial government of Gold Coast enacted an Ordinance for the management of the so-called "Lunatic Asylums" in 1888 (see chapter 2), but taking it into consideration would have been far beyond the ambitions and the dimensions of this study.

Methods

A textual analysis will be conducted on the legislation papers, in order to point out which are the words, the *topoi* (see below) and categories used to describe mental illness (and annexed discourses) and how mental illness is conceptualized in the documents. The analysis will rely on the field of the so-called "Critical Discourse Analysis" (CDA), a method of textual analysis used by different disciplines – most specifically cultural anthropology – which identifies language not only as a mean of communication, but also as an agent of action and social change (Wodak & Meyer 2001; Caldas-Coulthard & Coulthard 2003; Widdowson 2004; Wodak and Chilton 2005; Fairclough 2005; Herzog 2016). The scenario that will emerge from the analysis of the early text will be confronted with a similar analysis of the later one, in order to diachronically address the issue and be able to show how the governmental discourse on mental health changed from the promulgation of the first law (1972) to the second one (2012). The categories found to be relevant in the documents to trace the "ideological map" of mental illness in Ghanaian laws will be discussed using different theories from social sciences.

Theoretical framework

At this point, some theoretical clarifications are necessary in order to clarify how the object of this study (i.e., the legal texts) are conceived and how the discourse analysis and ideology are understood as the means and the objective of the research.

A law has a status of its own as a particular text, with its specific rhetoric, power and pragmatic effects. The anthropologist Raymond Apthorpe conceived policy documents (including legislative texts) as a literary genre, with their own "style" and "gaze". For Apthorpe, the style of the document is not just a secondary characteristic of the text; it is strictly connected to its power. Namely, the more a policy document appears clear and plain in its rhetoric, the more it acquires power, insofar as it shows itself as an absolute truth. In Apthorpe's words, in this way «a symbolic force is achieved» (Apthorpe, 1997:35). That is to say, the force can persuade the reader that the text contains an unconfutable truth. This is achieved by a no-frills style (plainness) and by taking away

from the texts elements that may be contradictory (clarity). These rhetorical devices operate to disguise the law, hiding its connection with politics, culture and human experience. Indeed, law, as a human artefact, cannot be studied separately from its cultural, social and political context. As Roberta Kevelson stated, law is a sign system which «represent[s] changing social norms and the evolving, growing social consciousness of any given community» (Kevelson, 1988:4, cit. in Wagner et al., 2005:4). Legislation is not an autonomous structure; it is embedded in non-legal discourses and practices (Wagner et al., 2005:6).

However, as mentioned before, the contextual and external elements which take part in the formulation of the law are not explicated in the legislative text itself. Moreover, laws are codified in a language whose semantic structure is not accessible to everyone, but only to legal experts. The risk is for law to become a system which is understandable only by the system itself (Wagner et al., 2005:7). Accordingly, this could lead to a lack connection between the normative statement and the actual context it claims to normalize, making it ineffective. In this sense, the analysis of the legislative documents (and of policy documents at large) is a crucial tool that must be put in practice to "go upriver", from the text to the context, from the plainness and clarity of the law to the complex world of meaning it stems from. In other words, since the law itself is the product of a particular system of codification, the role of policy analysis is to decode the text and unveil the matrix of signification which lies behind it, as the condition of possibility[1] of its own existence. This work is necessary to critically address the policy system, to show the contradictions, the incongruences and the weaknesses underlying its apparent perfection. In practical terms, legal text analysis is aimed to improve the policy itself, its intelligibility and its pertinence with the context of implementation.

As mentioned in the previous section, the analysis of the ideological background of the mental health laws will be carried out using Critical Discourse Analysis. In particular, in this study the *topoi* (sing. *topos*) that structures the texts will be put on evidence and

[1] Here, the expression "condition of possibility" is understood in Foucauldian terms. The conditions of possibility are defined as «the conditions necessary for the appearance of an object of discourse, the historical conditions required if one is to 'say anything' about it, and if several people are to say different things about it, the conditions necessary if it is to exist in relation to other objects, if it is to establish with them relations of resemblance, proximity, distance, difference, transformation» (Foucault, 2002:49). In our case, the reference is to the conditions which made possible the promulgation of a new law on mental health in Ghana, with its particular understanding of mental illness and of the subject affected by psychosocial disorders.

discussed. A *topos* can be described as one of the fundamental assumptions that a text is based upon. It is an argument that is not explained or demonstrated in the text, but that has to be taken for granted in order for the text to be rhetorically effective (Grue, 2009:290). A *topos* has two main characteristics:

> 1) [It] is that which justifies a line of argument, but requires less justification itself because it is anchored in common attitudes or *doxa*.
> 2) *Topoi*, being rules of inference, are tied more strongly to *concepts* than to *words*. The same *topos* can potentially be phrased in numerous ways, and so extraction of *topoi* will necessitate rewording. (Grue, 2009: 289)

At this point, it remains to discuss the main objective that the discourse analysis wants to bring out in this research: mental illness as an *ideology* in the legal texts. The philosopher Daniel Tarizzo identifies ideology with order. Ideology is not (only) a set of knowledge or rules. Rather, «it coincides with a certain arrangement of the discursive space, with a layout of enunciations in a certain hierarchical order» (Tarizzo, 2011:146). In other words, ideology does not explain what something *is*; it does not derive from hypothesis on the reality of an object. Rather, it "puts things together"; deciding what enunciations should belong to a certain field. In this sense, the concept of ideology is similar to Foucault's concept of "epistemological marker", defined as «a meta-discursive concept that has the function of circumscribing the boundaries of a jagged and disjointed epistemic field» (Tarizzo, 2011:147). In our context, then, "mental health" can be considered an epistemological marker that, as such, needs not to be defined by the actors, for the function of the marker "mental health" is to group together different scientific fields (e.g., psychology, psychiatry, etc.), politics and law. It is not to define or to give a better understanding of mental health. Ideology does not try to explain the nature of an object, but rather it justifies the grouping of certain institutions, scientific practices and political discourses around the same object to reach a specific purpose. For example, we may think how racist theories that were popular in social sciences from the middle XIX to early XX century and the imperialist policy carried out by European states in the same period are both part of a colonial ideology aimed at the subjugation of non-European populations.

The legal texts analysed here are both part and consequence of the ideology of mental health discourse in Ghana. On the one hand, mental health, as a particular epistemological marker, requires the intervention of the law. On the other, the law itself participates in the

formation of the discourse "mental health" using a certain set of principles and moral values – those that this analysis aims to bring out.

State of Research

From the day of the promulgation of the Mental Health Act in May 2012, academic analysts were not long to publish assessment of – and criticisms to – the new law. The same cannot be told for the Mental Health Decree which became effective forty years before, but that has never been actually implemented. Moreover, while the promulgation of the Act[2] shows that the Ghanaian state is – to a certain extent – concerned with the issues of people with psychosocial disorders, the copious literature on mental healthcare systems and on mental health policy in Ghana is symptom of a new interest on the subject on the part of the scientific community. It is possible that the rise of political and academic engagement in mental health issues, in turn, originated from the spotlight that news reporters and international organization such as Human Rights Watch and World Health Organization pointed on the abuses that people with mental disorders were meeting in prayer camps. Moreover, in the last years, non-governmental organizations like BasicNeeds and Mehsog (Mental Health Society of Ghana) are providing people affected by mental disorders with a precious support. For the professionals operating in the field, policy analysis is a crucial tool to pursue their objective in the most informed and conscious way. Their presence and their attempts to raise awareness towards mental health problems in the country may have helped in increasing the interest on the matter.

The scientific literature about mental health in Ghana focused mainly on three interrelated topics: mental health services, mental health legislation and collaboration with traditional healers. For the issue and the objective of this study, this section will deal with the published work on mental health legislation. It has to be noted that, even though the literature about the legislative framework of mental health services in Ghana is not

[2] The Mental Health Act is one of the rare "good examples" of mental health legislations in the African continent, together with South Africa, that in 2002 promulgated its Mental Health Act of South Africa. Other African countries are still implementing disparaging legislations, in which people with mental disorders are named "lunatic" or "imbeciles". Still, many African countries lack a mental health law at all (Alem & Manning, 2016:304-306).

scarce (compared to the amount of studies published on other African countries) it is nonetheless quite redundant.

As mentioned before, to date there is only one study on the Decree of 1972. In this paper, Drew and colleagues made an assessment of the legislative text on the base of the WHO Checklist on Mental Health Legislation, showing how, for forty years, the law was inappropriate in a human rights perspective. First, some crucial elements of the problem concerning mental patients were not properly addressed. The concept of mental illness itself was not defined. This could lead to ambiguities in the interpretation and implementation of the law. Moreover, the role of the family was not addressed clearly. This also can be source of problems, due to the crucial role the family has in caring for patients. Still, the issue of who should uphold the responsibility on mental patients is strictly connected with the concepts of competence and capacity attributed to people with mental disorders. In discussing resolutions such as involuntary reclusion and treatment, the last word was up to the magistrate, when he/she would have considered such resolutions "reasonable". Finally, there was no mention of the rights of the people with psychosocial disorders. This could be a result of the fact that the law had been written before the International Bill of Rights and the ratification of the Convention on the Rights of Persons with Disabilities (CRPD) (Drew et al., 2013).

The analysis that focused on the Mental Health Act concentrated on the challenges that the implementation of the legislation had/have to face in order to make the change it has been designed to. In other words, the literature confronted the strategies and the objectives of the Act with the resources and the infrastructures that are present on the territory, investigating whether the mental healthcare sector would have been able to satisfy the requests of the new legislative framework for mental health services.

The first of the challenges the mental health system had to face is the paucity of financial resources allocated for the implementation of mental health policy and the construction of mental health facilities. Soon after the promulgation of the Act, scholars lamented that the health sector alone was not able to bear the burden of the costs of implementation of the legislation (Doku et al., 2012:245). Years later there has been the confirmation that the situation has not changed: the mental health authority is still struggling with the lack of financial resources and, accordingly, programs defined by the Act are still to come (Walker, 2015:268; Van Driessche, 2016:145). The same can be told for human resources. Scholars agreed that mental health workers were few and ill-prepared. Moreover, the Ghanaian legal infrastructures are inadequate for the human rights part of the legislation to be implemented

(Walker, 2015:269). For the moment, some NGOs are carrying out the job of the Mental Health Review Tribunals that are planned by the Act (Doku et al. 2012:244), but that have never been created (Walker, 2015:269)[3].

Other scholars conducted more specific analysis. Anne Van Driessche evaluated the capability of the act using as "unit of measure" the guidelines established by the WHO Mental Health Policy and Service Guidance Package: accessibility, equity, comprehensiveness, coordination and continuity of care, effectiveness, and respect for human rights. The results of the research were consistent with the other studies. None of the WHO requirements were satisfied due to financial problems, geopolitical divides, lack of psychiatric personnel and the presence and influence of prayer camps (Van Driessche, 2016). Lastly, Ame et al. provided an analysis of the Act with a focus on the capability of the Act to protect the rights of children affected by mental disorders. The paper shows that in this field progress have been made in comparison with the previous legislations and, at least formally, the legislation meets the international standards set by the Convention of the Rights of the Child. However, the scholars wrote that to date there are not enough empirical data to tell if these parameters are applied on the field (Ame et al., 2016).

[3] Unsurprisingly, the list of the challenges that the Ghanaian mental healthcare system has to face can be very long. Important though each of them is, it is not the purpose of this section to analyse them all. For a complete understanding of the issue, see Ofori-Atta et al., 2010; Doku et al, 2012; Walker, 2015; Van Driessche, 2016; Walker & Osei, 2017.

CHAPTER II
MENTAL HEALTH CARE SYSTEMS IN GHANA

Before dealing in the specific with the legal texts that will be analysed in chapter 3, in this chapter the social and structural context of mental health facilities – both formal and informal, biomedical and "traditional" – is described. Namely, a brief historical background will be provided to diachronically address the subject of this study. Secondly, the current situation of mental health facilities in Ghana will be illustrated to show the context in which the last mental health law analysed in chapter 3 is to be implemented. Thirdly, I will describe the treatment that religious leaders and traditional healers practice in the so-called "prayer camps" of Ghana. It might seem that this last point is out of the context, but it is important to briefly deal with traditional practices: on the one hand, because in the next chapter I will be mentioning them; on the other, because the Mental Health Act of 2012 was also a reaction to the maltreatments practiced in these camps.

Historical Background

Unfortunately, to date there is no published work providing a comprehensive history of psychiatric practices, policies and institutions in Ghana. Therefore, any attempts to trace a historical background of the object of this study will undoubtedly show shortcomings and temporal gaps. This is particularly true if we are to describe the development of national policies on mental health. Not only this subject did not raise the interest of historians[4], but mental health concerns did not even raise the interest of Ghanaian state itself. Indeed, in the history of Gold Coast and Ghana together there have been very few regulation papers for mental health policy published by governments. In particular, there have been only three mental health laws, of which only two have been implemented. Of

[4] With the exception of Heaton, 2013.

course, policy documents alone do not make the history of mental health care in a country; nonetheless, they can represent crucial turning points in the practice and in the organization of psychiatric discipline and mental health services in the country.

Basically, the history of mental health in Ghana is from decades relegated in few lines in the introductory sections of articles dealing with mental health services in the country. All these short historical notes draw on an article appeared in 1962 on *Ghana Medical Journal*. It was authored by psychiatrist E.B. Forster, who devoted this short publication to the development of psychiatric services in the country, from the colonial period to his days. Through Forster's reconstruction, we can trace back the starting point of the history of biomedical mental health care to February 4th, 1888, when governor of the colony, Sir Edward Griffiths, signed the Lunatic Asylum Ordinance. The Ordinance was the first legislative instrument designed to regulate the treatment of mentally ill people, that at the time were called "lunatics" or "idiots". In practice, the Ordinance established a lunatic asylum in Accra, in the vacated building that used to host the High Court at Victoriaborg. Before the establishment of the Asylum, people were detained in jails. Indeed, the Asylum was commissioned to remedy the overcrowding of the prisons of the city, which until then were the only public structures designed to detain «those mentally ill who had become so unruly as to attract the attentions of colonial authorities» (Heaton, 2013). However, the function of the Asylum was merely one of custody and segregation. No treatment was offered and the staff was only asked to feed the inmates and report their mental health conditions to the authorities (Forster, 1962:26). As Heaton notes,

> Asylum space was typically reserved only for those whose mental illness posed a serious threat to themselves or others – that is, those with the capacity to disrupt the colonial social order. In Gold Coast, as in other African colonies, most mentally ill individuals were maintained in their local communities, by family, friends, and local authorities. (Heaton, 2013:378)

The exclusively securitarian approach in treating mentally ill people is supported also by the fact that the first psychiatrist operating in the country appeared only in 1951[5]. Forster attributes the lack of specialists in the country to the general attitude of African people

[5] With the exception of a brief intervention of an alienist in 1929 (Forster, 1962).

toward mental illness, «which, locally had been shrouded in witchcraft, juju, taboos, religious cults, fetish and Zar» (Forster, 1962:25).

Until the first years of the twentieth century, the Lunatic Asylum remained the only structure responsible for the treatment. In 1904, to remedy the overcrowded and inadequate condition of the inmates, the Mental Hospital at Accra was built and became operative in 1907. From 1951 the hospital ceased to have only a custodial function and psychiatric treatments started to be offered (Forster, 1962:26). At the end of his historical survey, Forster hoped for a future where psychiatry in Ghana would be always more aligned with the international standards and guidelines of the discipline and would have driven away from its local cultural background. In his vision, also the population would also gradually abandon seeking alternative forms of care for the treatment of mental illnesses, like those provided by traditional healers and religious shrines. More and more individuals would come to the hospital on a voluntary base (Forster, 1962:28).

Not only this view has been challenged by several academics who, by contrast, called for a collaboration between psychiatric services and traditional medicine (Read, 2012); but the population itself continued to seek mental health care both in psychiatric hospitals and in traditional shrines. Moreover, Forster's vision proved to be unrealisable for another reason: mental health facilities in Ghana are not equipped, diffused and numerous enough to cover the needs of the whole population.

The Current Situation of Mental Health Facilities

As many other African countries, Ghana has many obstacles to face in order to provide adequate mental health services. First of all, the country has huge financial problems. Obviously, mental illness is not the only problem that healthcare institutions must cope with. Mental issues are not perceived as a priority. Suffice it to say that the government spent less than 1% of national budget for mental healthcare in 2011 (HRW, 2012:27)[6]. This marginalization of mental illness among the priorities of the Ghanaian healthcare

[6] In Europe, the portion of health budget allocated for mental health services varies from 3% in Portugal to 13% in England and Luxemburg (Knapp & McDaid, 2007).

services is mirrored by a generalized lack of knowledge and awareness in what concerns mental illness on part of the public (Omar et al., 2010:4).

Secondly, 80% of the funds devolved in mental health services are allocated to the only three psychiatric hospitals of the country. Despite this, the hospitals barely manage to cover the fundamental needs of the patients, like feeding. Therefore, very little of the budget is left for effective interventions (Ofori-Atta et al., 2010:101). These data also show the lack of infrastructures and psychiatric facilities. The three psychiatric hospitals have in total 1,550 beds and are all distributed along the coast, in the cities of Accra and Ankaful (Ofori-Atta et al., 2010:102). Psychiatric services in general are present in just half of the district capitals and are concentrated in the south of the country, leaving the northern area with no service at all (Ofori-Atta et al., 2010:106).

Moreover, there is a huge lack of mental health workers. HRW reported that there are only 600 psychiatric nurses and 12 practicing psychiatrists nationwide (HRW, 2012: 27). This means that if there is approximately one traditional healer for every 200 people, the proportion for psychiatrists is one for every 1,470,588 people (Ae-Ngibise et al., 2010:559). Furthermore, several authors founded that social stigma is deeply rooted not only toward the mentally ill, but also toward their caregivers – nurses included – and from the mental workers themselves toward their own patients (Tawiah et al., 2015). On the one hand, this perception of the patient and their caregivers affects the quality of the services, since psychiatric nurses are often not motivated in healing their patients and adopt discriminatory behaviours toward them. Maltreatments have indeed been found also in psychiatric hospitals (Sadowsky, 2003). On the other hand, the stigma toward psychiatric workers makes their recruitment more difficult.

Lastly, there is a problem of governance that affects the process of policymaking. The healthcare governance structure in Ghana has a top-down approach, with no dialogue among the different strata of policy implementation. The policy process is led by the health ministry. However, the policymaking is carried out with the consultation of few senior managers at national level, with no consultation with lower level workers and users (Omar et al., 2010:6). This is combined with the decentralization of health care system structure, which devolves the implementation of policies to regions, provinces and districts. Still, local administrations lamented a lack of autonomy for the implementation of health programs: «regional mental health coordinators lacked the capacity to plan and

implement activities laid out in the policy and were not in a position to promote the prioritisation and resourcing of mental health services» (Omar et al., 2010:7). In addition, the unavailability of crucial data and information has been reported. This was attributed to a lack of mental health indicators and to the inability of psychiatric workers to register and distribute the information concerning the patients, due to an inadequate clinical skill and knowledge (Omar et al., 2010:5). In the same way, also the information needed to support policymaking was often lacking. Omar and colleagues reported that only a few mental health coordinators «were aware of the existence of policy documents» (Omar et al., 2010:6).

In short, the mental health services provided by the state show problems in every aspect: financial resources, infrastructure, personnel, governance, policymaking and database. Moreover, the stigmatization of mental patients and caregivers is present at all levels in the healthcare system, which makes the implementation of every intervention more challenging. It is not surprising, then, that people prefer to resort to traditional and faith healers to address cases of mental illness.

The Treatment of Mental Illness in Prayer Camps

In Ghana there are alternative facilities for the treatment of mental health problems which coexist with those provided by the biomedical health care system. These are represented by the broader community, traditional healers and religious leaders. The latter, in particular, instituted the so called "prayer camps", spaces in which – among other things – mentally ill people are treated: «Prayer camps are privately owned Christian religious institutions with roots in the evangelical or Pentecostal denominations established for purposes of prayer, counselling, and spiritual healing, and are involved in various charitable activities» (HRW, 2012:8). Usually, the camps are run by self-proclaimed "prophets" and are involved in many activities, from spiritual worship and counselling to commercial agriculture and medical care. Hence, the healing of mental cases is but one of the activities that are carried out in prayer camps. It is estimated that in Ghana there are several hundred prayer camps, although there is no census to date (HRW, 2012:30).

In Twi language[7], a mentally ill person is described as *bdamfo*, a term which defines an individual whose behaviour is considered "wild" or anti-social. It includes conducts like talking to oneself or in a disordered way, acting aggressively and dressing in dirty clothes (Read et al., 2009:5). Usually, it is the family of the *bdamfo* who takes him/her to a prayer camp, when the household is no longer able to cope with the strange or aggressive behaviour of the latter. The prayer camp is the first choice for many families, because of the lack of health care facilities in many regions of the country and/or their affordability. More often, however, the decision to resort to prayer camps is undertaken after having experimented the ineffectiveness of psychiatric care or the side-effects of medicines (Read et al., 2009:5).

Hence, a family benefits from the service provided by the prophets to protect its members from the strange or aggressive behaviour of the *bdamfo*, who may hurt the them both physically and symbolically – through the stigmatization that the mentally ill brings to the household. However, not only people with violent or bizarre behaviour are put in prayer camps. People whose behaviour is morally sanctioned can be subjected to the same treatment (Read et al., 2009:9). In this category there are cannabis smokers, people who break taboos, thieves and adulterers. Lastly, people opt for the reclusion in prayer camps to protect the patients from vagrancy, a very common behaviour among those affected by mental illness, who may easily wander away from home and get lost.

Once the patient is taken to a prayer camp, most of the times he/she is chained to a tree or to the pavement of a room. The shackling can be conducted with the collaboration of the family. The chains are removed once the person is considered "calmer". This can take weeks, months or even years, during which the individual is forced to permanently live in the space of about one square foot, and constantly exposed to the elements – in the case the *bdamfo* is chained outdoor. Relatives are usually expected to stay at the camp for assistance. However, the use of chains is not seen just as a "practical need" to immobilise the patient. It is part of the treatment:

> Using shackles [...] enabled healers to enforce treatment such as herbal medicine, 'fasting' and praying. In the case of Christian pastors, the chains then became part of fulfilling their divine mission. One pastor argued that he could not afford to build accommodation

[7] Twi language is a dialect of the Akan language and it is one of the most spoken languages in central and southern Ghana.

> at his prayer camp, so had no alternative but to use chains to carry out the work God had called him to. (Read et al., 2009:9).

Beatings are also part of the treatment. They are needed to free the person from evil spirits that are haunting the patient and causing madness. Healers argue that the patients are not suffering from the beatings, since the spirits are suffering on their behalf (Read et al., 2009:9). However, beatings are also practiced to extract confessions. The pastors uphold that none can be healed if their sins are not confessed.

In the same way, also the denial of food is seen as part of the healing process. Fasting is indeed a way to let the evil spirits starve and to make easier for the spirits of God to enter the body of the patient (HRW, 2012:8). The fasting schedule changes from camp to camp. The amount of time spent without food could range from having just one meal a day, to fast for some hours every day or even from morning to evening every day for two years (HRW, 2012:52).

As mentioned before, the harsh treatment dealt to people with mental illness in prayer camps inspired the reaction of human rights organizations, media and non-governmental organizations (see, for example, the already cited report by Human Rights Watch, 2012). Although difficult to prove, the spotlight directed to prayer camps can be one of the factors that triggered the process that lead to the enactment of a new mental health law in 2012. In its intention, the law aims to reshape the architecture of mental health services in order to establish a community-based oriented system of mental health facilities, in order to meet the needs of people in their local environment and, at the same time, to reduce the appeal of traditional and religious practitioners. However, the mental health law does not point out only this aspect of mental health. In the next chapter we will see how in the Ghanaian mental health laws ideological and moral values are embedded in the legal texts themselves. Discourses concerning the function of mental health regulations, ideas about the nature of mental illness and on the identity of mentally ill people themselves are at the base of the composition of the legal texts and have pragmatic outcomes at the moment of implementation of mental health policies.

CHAPTER 3
IDEOLOGY AND MENTAL HEALTH IN GHANAIAN LAWS

After having described the situation of mental health services and institution in Ghana, we can narrow our focus on the legislative texts which were/are supposed to set the institutional and administrative framework in which mental health workers and facilities should operate. As already mentioned in the introduction, this analysis is not going to explore the possibility of – and/or the challenges to the – implementation of the legal framework for mental health services in Ghana. In other words, the aim of this analysis is not to compare the *formal* prescriptions of the law to the *actual* world of mental healthcare services, institutions and professionals in the country[8]. Rather, this study looks in the opposite direction. That is to say, to find the ideological and moral assumptions that lie beyond the composition of the texts themselves, assuming the legal discourse on mental health as the reflection and the result of ideological and moral values concerning mental health, mental illness and people affected by mental disorders. The goal is to trace a sort of "map" of the values that are embedded in the institutional discourse of mental health in Ghana.

In the analysis of Ghanaian mental health laws, three main *topoi* (see Introduction, p. 4) have been found. The first *topos* answers the question "why?"; it is concerned with giving a justification to the law itself in the field of mental health. This is one of the point that did not change from the Mental Health Decree of 1972 to the Mental Health Act of 2012. Namely, at the core of both laws, the justification for the normalization of mental health facilities is given for reasons of *public safety*. The second *topos* answers to the question "who?" and deals with the subjectivity of the person affected by mental disorder or mental illness. That is to say, how the legal texts create the subject they want to act upon. In both the texts of 1972 and 2012 there is the construction of the mentally ill as a dangerous person and as a person lacking competence, capacity and intentionality. In

[8] It has been shown that there is already a copious literature on this issue (cf. *infra*, p. 7).

2012, however, this discourse is broadened by a human rights rhetoric that depicts the person with mental disorders as a victim of society. Lastly, the third *topos* answers to the question "what?" and is concerned with the ontology of mental illness. In this respect, there is a shift in the perception of mental suffering: forty years ago, mental illness was perceived to be primarily a problem of the single individual and of his/her body, while nowadays mental disorders are found to be (also) problems of adaptation in the society. In other words, the focus of mental illness shifted from the individual alone to the relationship between the mentally ill and his/her social environment. These different conceptions of mental illness have profound effects in the organization of mental health services and facilities.

Mental health as problem of public safety

One of the central themes that is employed both in the Decree and in the Act is the concern for the safety of the people, in terms of bodily protection from harmful actions performed by other people. In *table 1* there are some of the extracts in which references to safety is mentioned. It is observable that the concern for safety encompass almost all the topics the laws are dealing with, even if the matter is expressed in different ways. Namely, in 1972 there is a recurrent and explicit mention of "public safety", whilst in 2012 the formula is that the patient may be "a danger to his/herself of to others".

Topic	**Mental Health Decree (1972)**	**Mental Health Act (2012)**
Discharge	Where application is made to the Tribunal by or in respect of a person detained under this Decree, the Tribunal may in any case direct that the patient be discharged, notwithstanding the previous order of any Magistrate, and he shall be discharged accordingly; and the Tribunal shall so direct if they are satisfied – [...]	The Tribunal shall direct the discharge of a patient where it is satisfied [...] (b) that it is not necessary in the interest of the health or **safety of the patient or for the protection of other persons** that the patient should continue to be detained, or (c) that the patient if released is not likely to act in a manner **dangerous to the patient or to others**

	c. that the patient, if released, would not be likely to act in a manner **dangerous to himself** or to others.	
Objective of treatment		The recommendation shall specify in full detail [...] *(d)* that the treatment is necessary to bring about an improvement in the person's condition, restore capacity to make treatment decisions, prevent serious deterioration or prevent injury or **harm to self or others**.
Involuntary seclusion	Any informant may give to a magistrate information on oath, supported by two medical recommendations, to the effect that it is expedient for the welfare of any person believed to be suffering from mental illness, or for the **public safety**, that such person should be forthwith placed under care, observation and treatment in a psychiatric hospital. Where the magistrate is satisfied as a result of his enquiry under subsection 3 that there is good reason to believe the person in question to be suffering from mental illness, and that it is expedient for his welfare, or for the **public safety**, that he should forthwith be placed under care, observation and treatment in a psychiatric hospital, the magistrate may order that such person be placed under care, observation and treatment in a psychiatric hospital for such period, not exceeding six months, as the magistrate thinks fit.	A person may be placed in involuntary seclusion or minimal mechanical restraints only when there is imminent **danger to the patient or others** and tranquilisation is not appropriate or not readily available.
Employer's rights		The employer or another person may follow the procedure for a certificate of urgency under section 48 where the situation of a worker is suspected to be severe enough to be treated as an emergency case or where the worker is at **personal risk or a risk to others or property**
	If a police officer finds in a place to which the public have access any person who appears	A District Assembly shall liaise with the police, social welfare and health authorities to remove persons

Persons found in public places	to him to be suffering from mental illness and to be in immediate need of care or control the police officer may, if he thinks it necessary to do so in the interest of that person or for the protection of other persons, remove that person to a **place of safety**.	with mental disorder who are a **danger to themselves or to others** and found in public places in the district to a facility or mental health facility for treatment and rehabilitation.
Informed consent		(3) Despite subsection (2), written consent to provide confidential information may be waived where there is a **risk of imminent danger to another person** or where the disclosure is required by law.
Emergency cases	Notwithstanding the provisions of section 8, in a case of urgency where it is expedient either for the welfare of a person suspected by a medical officer to be suffering from mental illness, or for the **public safety**, that such person should be forthwith placed under care, observation or treatment, registered medical practitioner may certify the case as one of urgency and thereafter such person may be received and detained in a psychiatric hospital in accordance with this section.	(2) Where a delay in obtaining the informed consent may be **dangerous to the life of that person**, the procedure may be carried out and the Tribunal shall be informed at the earliest possible time after the procedure. [...], in an emergency case where it is expedient either for the welfare of a person suspected to be suffering from mental disorder or for **public safety** because of the person suspected to be suffering from mental disorder, a police officer, a relative or any other person with or without the assistance of a police officer may take the person to a facility or mental health facility for a certificate of urgency to be issued under sub-section (2).
Prolonged treatment	Where a person is under care, observation and treatment in a psychiatric hospital pursuant to an order for temporary treatment made under section 8, and the Chief Administrator of the hospital is of the opinion that, by reason of the severity or nature of the mental illness it is necessary for the welfare of such person or for the **public safety** that he should forthwith be placed under prolonged treatment in a psychiatric hospital, the provisions of this section shall apply.	A psychiatrist or head of a facility may recommend the place- ment of a person under a temporary treatment court order for a pro- longed treatment in a psychiatric hospital if the psychiatrist or head of a facility is of the opinion that the severity of the condition warrants it. (2) This recommendation shall take into consideration the wel- fare of that person and the **safety of the public**.

	in the circumstances referred to in subsection 1, the Administrator shall, before the expiration of the order for temporary treatment made under section 8, give to a magistrate information on oath, supported by a medical recommendation, to the effect that it is necessary for the welfare of the person suffering from mental illness, or for the **public safety**, that such person should be forthwith placed under prolonged treatment in a psychiatric hospital.	

Table 1. Extracts from the Mental Health Decree (1972) and the Mental Health Act (2012). The concern for public safety is one of the crucial themes in both the laws.

As we can see, the concern for public safety is crucial in many aspects. First of all, making sure that a patient is not dangerous for his/her own safety and for the safety of other people is a precondition for that person to be discharged from a psychiatric hospital. Accordingly, making a person harmless is one of the objective of the psychiatric treatment as conceived by the Act. Moreover, if a person is suspected to be able to undermine the public safety, he/she can be subjected to a period of involuntary seclusion that potentially could be extended indefinitely, until the medical and legal authorities consider it appropriate. In cases of emergency, it is not even necessary to prove that a person is actually suffering from mental illness to restraint him/her. From 1972 to 2012, a person could be detained up to 14 days without the intervention of a legal authority. For logistic problems or in cases of escape from psychiatric hospitals, the person could be detained in prison or in any other places under the supervision of a police officer for the same period of time. In 2012, the amount of time in which a person could be detained without a warrant from a magistrate has been reduced to 48 hours, during which the medical and legal authorities are supposed to clarify if the person needs a treatment or could be released.

It is not surprising that a sovereign state makes enactments to safeguard the public safety of its citizens. It is not obvious, however, that such measures to promote public safety are included in mental health laws. In political philosophy, the commitment of the state to protect the people living within its borders is at the base of the social contract – conceptualized for the first time by Thomas Hobbes in 1651 – that citizens and the sovereign power stipulate giving shape to the nation. Following Hobbesian thought, it is for the sake of our safety, for the protection against people and things who may attempt

to endanger our biological survival that we exchange part of our liberty in favour of a social control by the sovereign – the "Leviathan", in Hobbes' words (Waldron, 2006:457). Of course, the discourse on public security is not the same as four centuries ago. Nowadays, we do not expect from the state the mere protection of our biological survival; we expect us to be granted the best quality of life as possible. We do not want just to "be alive", we want a "good life" (Waldron, 2006). However, the basic structure of Hobbesian ideology and vocabulary is still at the core of the discourse on public safety and security.

Hobbesian thought is interesting for our case in respect to the use that the state makes of the law on mental health. Namely, it provides useful insights concerning the topic of the distribution of public security. The right not to be harmed by other people is fundamental for us to enjoy our liberty. Yet, as opposed to other rights, safety may be not conceived in absolute terms. Shortly, an example of a rights conceived in absolute terms in modern democracies is the right to vote: unless *all* the citizens in legal age living in the national territory can enjoy the right to vote, a state could not be considered a democracy as such. With public safety, we may assist to another conception of distribution of the rights. That is to say, the "maximizing model", where the state does not feel the need to make possible for everybody to enjoy a certain degree of safety and security, but the aim is to distribute it to as many people as possible (Waldron, 2006:478). This means that some people may enjoy more safety and security compared to others. This conception of the distribution of safety among the population has crucial consequences. In fact, it implies that some people's freedom may be sacrificed for the safety of the majority of the population. In other words, in this way public safety may be compared to a good that can be obtained in exchange to some people's freedom.

The emphasis put on public safety in the legislations of mental health in Ghana serves this purpose. The law on mental health make it possible to deny to people who have not committed any crime their rights to freedom and their rights of decisions. In this sense, the rights of people suspected to be suffering from mental health illness turn into a sort of currency: a good that can be exchanged for another good. Specifically, their freedom is exchanged with public safety which can be enjoyed by other people.

Anyhow, it is not uncommon to find such emphasis on public safety inside the laws on mental health in different countries of the world. Uri Aviram called this approach to

mental health law the "legalistic model", as opposed to the "medical-psychiatric" model. The two models reflect a distinct set of premises and different values. Whilst the latter is characterised by a focus on the need for treatment and on the health of the patients, the former puts at its core the «dangerousness criterion for commitment» and the management of civil liberties (Aviram, 1990:163). Moreover, the medical-psychiatric model accords more discretion to psychiatrists in what concerns the admission to the hospital, the treatment and the cases of involuntary seclusion in a psychiatric facility. The legalistic model, by contrast, does not regard these topics as purely medical issues and as responsibilities of the medical staff. It places emphasis on the social control of patients in order to guarantee public safety. Accordingly, the health needs are put on the backdrop of mental health regulations. In this sense, the protests that occurred among the psychiatrists in USA in the 1970s are telling. The new US law on mental health, oriented in a legalistic model approach, met the disappointment of many practitioners, who saw themselves relegated into a role of social control agents, rather than being at the service of their patients' health (Aviram, 1990:164).

Even if Ghanaian law on mental health included the discourse of the rights of patients only in 2012[9], the legalistic model, in its guise of making the mental health law first and foremost a mechanism for social control, is present both in the Decree and in the Act. However, even if the legalistic approach on mental health law and its emphasis on public safety seems to be the standard form of mental health services regulation body in many countries, it is nonetheless not obvious that a sovereign power uses legislation on mental health to pursue objectives that fall outside the sphere of mental health in the strict sense. In other words, there is no doubt that a person who is suffering from mental disorders can be dangerous for him/herself or for the other people and that some precautionary measures should be taken in order to protect them. However, it is not justified for a potentially dangerous person to be automatically suspected of being affected by mental illness and treated accordingly; for dangerousness is not the first and the only marker of mental illness and may be caused by a plethora of other factors.

The problem is understandable if we consider once again the exercise of the state power in the context of its sources of legitimization. Basically, a democratic state is not

[9] Below in this chapter, we will argue how the absence of patients' rights in the legislation of 1972 may be a result of the fact that at the time of its enactment, the International Bill of Right and the Convention on the Rights of Persons with Disabilities (CRPD) were not present yet (Drew et al,, 2013).

able to undermine the right of freedom of people who did not commit any crime and did not break any law. It is part of the social contract that the citizens stipulate with the sovereign. Therefore, the sovereign power makes use of psychiatry, as a "discourse of truth" (in Foucauldian terms) to legitimize interventions that otherwise would not be possible within a democratic state. Psychiatry – and medicine in general – enjoy the status of a scientific discipline, and make enunciations that are considered "true" and, as such, have effects of power. In our context, this power goes beyond the legal power itself (Bizzarri, 2010:14). In other words, the state cannot deny the freedom to a person who is acting weird in public places before he/she commits a crime. However, appealing to a "discourse of truth" (i.e., psychiatry), the state can guess that that acting weird is symptom of a mental disease, that the person is not able to understand the basic moral rules of society and, accordingly, that that individual represents a danger. In this way the sovereign power finds in psychiatry the source of legitimation to put in place a form of social control that otherwise would have no justification.

To conclude, we can say that in the law we find a peculiar articulation between the medical and the political power, whose entanglement generate effects of power that go beyond the mere administration and the promotion of mental health. In fact, we have seen how one of the first concerns of the mental health laws is the public safety; the control of people suspected to be dangerous for other people is more discussed than the mental health issue itself. In this sense, this mechanism of power falls into the definition of what Foucault calls "apparatus": «a texture of entwined discursive and extra-discursive practices – however heterogeneous – that articulates itself in the forms of what we could define as an acted-out knowledge» (Tarizzo, 2011:140). The Decree and the Act under examination here are crossroads in which two different discourses meet each other. On the one hand, we have the discourse of the sovereign state whose first concern is public safety; on the other, we have the medical-psychiatric discourse that function as a discourse of truth that legitimates the social control of people suspected to be suffering from mental disorders. This is not to say that mental health is not a concern of both the state and psychiatry. Mental health could be the priority for the practitioners, but is only a secondary concern in the legislative texts, which are first and foremost an expression of the political power.

The Subjectivity of the Mentally Ill

The second *topos* found in the legislative texts is to a great extent strictly connected with the first one. This *topos* defines the subject the law aims to act upon. The question we are approaching in this section is: who are the mentally ill, as conceived by the Mental Health Decree and by the Mental Health Act?

Following the analysis that led us to identify the promotion of public safety as the main reason of existence of mental health laws, a primary feature of the mental patient as depicted by the Ghanaian state emerges spontaneously. In fact, the mentally ill person is, first of all, a potential danger for him/herself and for other people. It is interesting to note that, as we mentioned above, the law is put in practice *before* a person has been proved to be mentally ill by psychiatric practitioners. Suffice it for a person to be *suspected* to be mentally ill to perform the prescriptions defined by the law.

The role of suspicion is crucial in mental health policy in Ghana. Both in the Decree and in the Act, the suspicion of the presence of mental illness is crucial in many aspects. In the Act, for instance, in an "emergency case" the suspicion of a person suffering from mental disorder is the only element required to take the person to a psychiatric facility against his/her will. It also justifies the intervention of police officers to carry the potential patient to the healthcare structure. This provision is even more coercive of the precedent adopted in 1972 for the management of an urgent case. In the Decree, in fact, the suspect should be justified by a medical practitioner, before the person could be conducted to the psychiatric hospital by force. In both instances, however, what constitutes an "emergency case" or a "case of urgency" is not defined. In the Act, in particular, there is only a tautological, illusory and useless definition: «"emergency case" means an urgent case» (*Mental Health Act*, 2012). The fact of emergency case being unspecified makes the prescription even more coercive, because it relies on the discretion of other people to define the dangerousness of a person, without any recommendation of a psychiatric practitioner[10]. In the same way, the suspicion of mental illness works to remove people from public or private places if it is believed that a person is not able to care for himself

[10] It is opportune to remember here that this provision is applicable to people who did not commit any crime or offence, in which case the guilty shall be treated in accordance with the appropriate legislation. This further overshadows how an "emergency case" should be understood in the Mental Health Act.

or if he/she is ill-treated by other people. There are no substantial differences, in this respect, between the Decree and the Act. However, in 2012 the suspicion of mental illness is extended in other fields, like at workplace and in cases of offenders. In short, in the first case an employer is given the right to denounce to mental health facilities cases in which it is thought that mental illness is affecting the work of an employee; in the second case, it is prescribed for a person who committed an offence to be carried to a psychiatric hospital instead of prison if he/she is suspected to be suffering from mental disorders. In the table below it is showed when the legal texts explicitly mention the power of suspicion.

	Mental Health Decree (1972)	**Mental Health Act (2012)**
Objective of the law	The provisions of this decree shall apply to persons **suffering or believed to be suffering** from any degree of mental disorder, psychopathic disorder, arrested or incomplete development of mind, mental subnormality or any other disorder or disability of mind, howsoever called, as they apply to persons suffering or believed to be suffering from mental illness.	
Involuntary admission	Any informant may give to a magistrate information on oath, supported by two medical recommendations, to the effect that it is expedient for the welfare of any person **believed** to be suffering from mental illness, or for the public safety, that such person should be forthwith placed under care, observation and treatment in a psychiatric hospital.	The temporary treatment order will place the named person under the care, observation or treatment in a psychiatric hospital or any other facility which is approved under this Act for the care of involuntary patients, in as least restrictive an environment as is compatible with the health and safety of the person and society. [...] *(c)* that that person is **suspected** to lack capacity to make informed treatment decisions
Emergency case	Notwithstanding the provisions of section 8, in a case of urgency where it is expedient either for the welfare of a person **suspected** by a medical officer to be suffering from mental illness, or for the public safety, that	Despite section 42, in an emergency case where it is expedient either for the welfare of a person **suspected** to be suffering from mental disorder or for public safety because of the person

	such person should be forthwith placed under care, observation or treatment, registered medical practitioner may certify the case as one of urgency and thereafter such person may be received and detained in a psychiatric hospital in accordance with this section.	suspected to be suffering from mental disorder, a police officer, a relative or any other person with or without the assistance of a police officer may take the person to a facility or mental health facility for a certificate of urgency to be issued under sub-section (2).
Workplace		Where an employer has reasonable cause to **believe** that a worker is suffering from mental disorder severe enough to affect the work output of the worker, the employer may assist the worker to seek medical advice in accordance with the prescribed procedure. The employer or another person may follow the procedure for a certificate of urgency under section 48 where the situation of a worker is **suspected** to be severe enough to be treated as an emergency case or where the worker is at personal risk or a risk to others or property.
Removal from public or private places	If it appears to a Magistrate, on information on oath laid by any person, that there is reasonable cause to **suspect** that a person believed to be suffering from mental illness – a. has been, or is being, ill-treated or kept otherwise than under proper control, in any place within the jurisdiction of the Magistrate; or b. being unable to care for himself, is living alone in such place, the Magistrate may issue a warrant authorizing any police officer, if need be by force, any premises specified in the warrant in which that person is **believed** to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under section 8, or of other arrangements for his treatment or care.	Where it appears to a court on information on oath given by a person that there is reasonable cause to **suspect** that a person **believed to be suffering** from mental disorder […] is living alone in a place and is unable to provide self-care, the court may issue a warrant authorising a police officer to enter the premises specified in the warrant to remove that person to a place of safe custody to make an application for that person under section 42 or to make any other arrangements for the treatment or care of that person.
Case of offence		An offender **suspected** to have mental disorder at the time of the commission of the offence shall be sent to a psychiatric hospital for assessment and if found to have

		mental disorder shall be committed to treatment.

Table 2 Extracts from the Mental Health Decree (1972) and the Mental Health Act (2012). Suspicion is one of the elements that makes the mental health laws a tool of control.

From these observations we can argue that the subjectification of the mentally ill as an individual who may be potentially dangerous allows the enactment of practices aimed at the control of these subjects well before their dangerousness – as well as their mental illness – can be proved. This mechanism recalls what Nancy Campbell named "technologies of suspicion", defined as «a set of empirical modes for producing and interpreting "data" [...] in ways that conflate prediction with prescription, acting as technological form of supervision, monitoring, supposed deterrence and ultimately control» (Campbell, 2004:78). In our case, the "data" that the mental health laws contribute to generate as technologies of suspicion is the mentally ill subject with its inner and unjustified characteristic of dangerousness. This conception of the mentally ill, together with the power/knowledge of psychiatry (as we discussed in the previous section, cf. Foucault, 1980), makes it possible to create a system of control that is not exercised only by police officers, but that is diffused also among the common citizens. Campbell calls this process "decentralization and deinstitutionalization of distrust" (Campbell, 2004:78). The technologies of suspicion, in fact, are based on distrust. Thus distrust, on the one hand, is institutionalized, for the state enacts a law that enables the seclusion and the coercive control of people on the base of the suspect of mental health. On the other hand, at the same time the law decentralises and deinstitutionalises the distrust because it delegates the control to people other than state's officers. For example, we have seen how, in cases of "emergency", whoever can denounce and seclude a person on the base of the only suspect of that person being affected by mental illness and, hence, of being a danger for him/herself and for the other people. This process is even more effective since it is impossible to know what "emergency" means.

Thus, the mental health laws examined here contribute to a capillary dispersion of suspicion within the society. The corollary for the state is a better governability and a better control of people for the sake of public safety. In other words, this means that the control of the deviant behaviour is enacted not only thorough disciplinary bodies (e.g., police officers), but also through other people such as relatives, teachers or employers who may denounce a case of mental illness. Campbell finds in this form of control to be

a characteristic of the so-called "post-disciplinary surveillance regimes" (Campbell, 2004). However, we would be wrong if we think that the only purpose of these mental health laws is social control. In fact, we cannot deny that people with psychosocial disorders can actually be dangerous and that the measures prescribed by the legislative texts can be useful, or even of vital importance, to prevent the harm of people. Social control and healthcare should be thought here as two sides of the same coin or, more precisely, as a system of governance that kills two birds with one stone: mental health services are provided only within a policy framework that diffuse the behavioural control of people to prevent actions that may undermine the public safety. In this sense, Nancy Campbell speaks about "coercive compassion" and "compassionate coercion" that characterise the technologies of suspicion (Campbell, 2004:81).

Another characteristic of the "mentally ill" subject as conceived and conceptualised in the legislative documents is the lack of competence and capacity that the patient can manifest in different degrees. Here we find the first drastic differences between the Mental Health Decree and the Mental Health Act. In fact, in the law of 1972 (which is way less complex and shorter than the Act) there is no mention of the capability of the mental patient to be able to make decisions on his/her own about the treatment he/she was going to be subjected to. These crucial decisions were not even delegated to relatives or to other people close to the patient. Accordingly, every choice regarding the detention in the psychiatric hospital and the practices of care, observation and treatment that the psychiatric practitioners wanted to implement were completely up to the medical personnel and – above all – to the magistrate. In fact, the task of the psychiatrist was to convince the magistrate that a person was suffering from mental illness and that – accordingly – was a risk for public safety. After an enquiry on the one "accused" of mental illness, the magistrate (who may not have any notion of medicine, psychiatry or psychology), if convinced of the medical recommendation provided by the psychiatrist, could order the detention of that person into a psychiatric hospital[11]. In short, the procedure – as specified in the document – was compared to a "summary trial". Only at a later stage the patient or any other person could apply to a tribunal, asking to review the decision of involuntary treatment. The same procedure should be applied to discharge a

[11] Ironically, despite the coercive character of the prescription for the detention in a psychiatric hospital, in the Mental Health Decree the expressions "involuntary treatment" or similar are not even used.

patient from the hospital. In other words, the patient had the possibility to ask for a revision of the treatment or to put an end to it, but it was on the discretion of the medial practitioners and of the court to infer in what extent the patient had the competence and the capacity to be responsible of his/her own action and to what extent the patient's words were trustworthy.

In 2012, the concepts of competence and capacity becomes central in what concerns the administration of people with mental disorders. First, the «suspect to lack capacity» is one of the necessary conditions for a person to be subjected to voluntary treatment. Accordingly, restoring the capacity of the patient is one of the objective of the treatment itself. Moreover, a person who is believed to lack capacity is provided with a guardianship «for the personal protection of that person» in what concerns the spheres of life that the person is not able to administrate alone, like personal or financial affairs, business, occupation and marriage. In the document, the concepts are defined as follows:

> "capacity" means the functional ability to understand or form an intention with regard to an act and a person including someone with mental disorder is presumed to have capacity until reliably proven otherwise.
>
> "competence" means sufficient capacity to understand an issue and manage a situation as determined by a court. (*Mental Health Act*, 2012)

The definitions of competence and capacity are in part tautological, since capacity is intended as the «ability to understand ...» and competence as the «*capacity* to understand ...» (*Mental Health Act*, 2012). However, an important difference can be traced, for capacity is conceived as the ability to form an intention – it is thus limited to a faculty of thought. Competence, by contrast, is identified with the qualification of managing a situation – it is a matter of practical ability. The element they have in common is that both have to be proven (by a psychiatrist) and determined (by a tribunal).

However, taking into consideration the lack of competence and capacity that a person may manifest, if on the one hand may lead to provide the patient with forms of protection and care where they are needed, on the other hand it can reduce the freedom and the possibilities accorded to the person affected by mental disorders. For example, in accordance with an assessment of capacity, the rights that a patient can enjoy can be reduced:

> A person with mental disorder has the right to enjoy a decent life as normal and as full as possible which includes, the right to education, vocational training, leisure, recreational activities, full employment and participation in civil, economic, social, cultural and political activities and *any specific limitations on these rights shall be in accordance with an assessment of capacity*. (Mental Health Act, 2012, emphasis added)

Thus, also in this case we find the combination and integration of coercion and compassion (Campbell, 2004) that is accorded to mental patients, a structure that encompasses the whole policy of mental health in Ghana as well as in other countries.

The situation in which the concepts of competence and capacity show their operability the most is perhaps the case of offence. If a person who commits an offence is suspected to be mentally ill, in fact, he/she is treated differently from the other criminals. The guilty may even spend his/her penalty in a psychiatric hospital instead of a jail:

> An offender suspected to have mental disorder at the time of the commission of the offence shall be sent to a psychiatric hospital for assessment and if found to have mental disorder shall be committed to treatment.
>
> An offender undergoing treatment at a psychiatric hospital shall have the same rights as a non-offender in treatment, including the right to judicial review by the Court. (*Mental Health Act*, 2012)

This is another great change from the Decree of 1972. If then an offender with mental disorders was considered completely responsible for his/her own actions, from 2012 the agency and the responsibility accorded to a person variate according to the competence and the capacity of the person at the moment of the crime. Mental illness, in this sense, deprives the person of his/her own agency, because it is believed that the illness is overwhelming the self of the individual and is transforming his/her values (Maibom, 2013:264). It is in this sense that mental illness affects the field of morality. The mentally ill is not believed to distinguish right and wrong as understood by the other people. As Maibom wrote:

> any person who has values that contrast sufficiently with ours, and who holds on to such values doggedly, suffers from essentially the same deficit as the insane, barring laziness, distraction, and greed. The consequence is that people with significantly

> different moral values are not responsible, or at least not fully responsible. (Maibom, 2013:265)

In this sense, the mentally ill is considered an individual who is morally different from the rest of the population. The Act allows a sort of "moral exclusion". Accordingly, restoring the capacity of a person affected by mental disorders can be read as taking a person back to the community that shares a common accepted morality.

One last crucial aspects regarding the subjectivity of the person affected by mental disorders and that the Act of 2012 brought as a novelty, is the emphasis put on the rights of the people with mental illness. A whole section of the new law is dedicated to the rights of the patients, ranging from the right of non-discrimination to the right of privacy and autonomy; from the basic human rights to the employment rights. It is not surprising that this "rights turn" in the legislation on mental health appeared only in 2012. In 1972, in fact, both the International Bill of Rights and the Convention on the Rights of Persons with Disabilities (CRPD) were still to be ratified (Drew et al,, 2013). It is not even surprising the emphasis put on the rights in 2012 if we think that the law was born also in reaction to the maltreatments that people with psychosocial disorders were meeting in prayer camps (HRW, 2012).

In short, the rights turn of the Mental Health Act can be considered a reaction to the diffused victimisation of people affected by mental disorders in the country. This, in turn, suggests that the law actually views people with mental illness as victims. Once again, here we find a sort of paradox, for the law aims to protect and give dignity to mentally ill people when the law itself, with its prescriptions, contributes to the same victimisation and the same discrimination of the mentally ill subject. As we have seen, the prescriptions of the law start to function well before that a person can be proven of suffering from mental illness. The process is comparable to the stigmatisation process, for it discredits and rejects a person on the base of a (suspected) attribute (Goffman, 1963). In this sense, mental health law makes it possible for a person to resemble his/her mental disorder and his/her dangerousness before the presence of the disorder can be proven and before the dangerousness of the subject manifests its effects (Bizzarri, 2010:15). As remarked by Foucault, «the supervision of the individuals is carried not at the level of what one does but of what one is, not at the level of what one does but of what one might do» (Foucault, 1994; cit. in Campbell, 2004:85).

The Ontology of Mental Suffering

The last *topos* found in the discourse analysis of the legal texts refers to the nature of mental suffering. It concerns the way mental illness is conceived and conceptualised and the consequences of different ontological understandings of mental disorders on the architecture of mental health services.

So far, I have used indistinctly the terms "mental illness" and "mental disorder", considering them as synonyms. However, also here the two texts show a great difference. The Mental Health Decree, in fact, shows a prevalence of the use of the expression "mental illness", whilst in the Mental Health Act this expression is non-existent and is substituted by the term "mental disorder". In the Decree, the expression "mental illness" recurs 16 times and "mental disorder" 5 times. In the Act, on the contrary, "mental disorder" recurs 110 times, while "mental illness" is not present at all. There is just the word "illness" (without the adjective "mental") which appears once.

It is true that the expressions "mental illness" and "mental disorder" denote partly overlapping concepts and that they may be used interchangeably[12]. However, illness and disorder are different in a crucial aspect. Both the concepts define illness or disorder as a dysfunctional physical and/or psychological state, an alteration from the normal functioning of the brain and of the mind. However, while "illness" emphasizes a malfunctioning at the level of the individual and of the body, the concept of mental disorder – although it does not question the presence of a bodily dysfunction – put the emphasis on the behavioural alteration of the subject in relation to his/her social environment of belonging. The patient, in the latter case, is not considered apart from the community.

Of course, we cannot base our discussion only on the formal definitions of these terms. The definitions of the medical dictionaries do not tell how the concepts of mental illness and mental disorder are used and understood in the legal texts under examination here. However, there are also historical developments that could help to understand the conception of mental suffering in Ghanaian legislation from 1972 to 2012. In the edition of the Diagnostic and Statistical Manual of Mental Disorders that was circulating at the

[12] In some medical dictionaries the definitions of mental illness and mental disorder are virtually identical, see, for example, the definitions given by The American Heritage® Medical Dictionary: http://www.yourdictionary.com/about/the-american-heritage-medical-dictionary.html

time of the promulgation of the Decree (DSM-II), psychiatry was considered «as an extension of medical practice» (Ramirez, 2018). At the same time, however, the psychoanalytic influence was very pronounced. Mental illness, thus, was considered both as a result of brain malfunctioning and as the manifestation of underlying psychological conflicts (Ramirez, 2018). In short, the focus of mental illness for psychiatric practitioners was the body and the mind of the individual. Of course, social factors were present as variables that could influence the mental health of a person, but they were not at the core of psychiatric practice.

At the time of the promulgation of the new Mental Health Act, the fourth edition of the DSM had been published (the fifth edition will appear one year later, in 2013). The editions of the DSM ranging from the third to the fifth are considered as a turn in comparison with the first two editions. The psychiatric manual, indeed, shifted from a biomedical and psychoanalytical approach to the so-called "bio-psycho-social model", which is the referential model for practitioners today. For the bio-psycho-social model

> a mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above (American Psychiatric Association 2013, cit. in Ramirez, 2018).

In short, it is arguable that, following the scientific and historical development of the conception of mental illness/disorder in psychiatry, also in the legislative texts we find a shift from an ontological understanding of mental suffering to another one. Specifically, a shift from an ontological assumption that emphasised the body and the individual sphere of the subject to another one – based on the bio-psycho-social model – which englobe and put on the same level the body, the mind and the society as agents that may cause mental suffering, as we can read in the quotation above.

As mentioned before, the shifting of the ontological understanding of mental illness/disorder is not only reflected in the different words used to define mental

malfunctioning. It is reflected in the whole organizational structure of mental health services, as summarised in the table below.

Topic	**Mental Health Decree (1972)**	**Mental Health Act (2012)**
Naming of mental suffering	Mental Illness	Mental disorder
Focus of aetiology	Body/mind	Body/mind/society
Centre for treatment	Psychiatric hospital	Mental health facilities
Person under treatment	Patient	User
Objective of treatment	Curing	Rehabilitating/reintegrating

Table 3 Synoptic presentation of the elements of the architecture of mental health services that changes with the shift in the conception of the ontology of mental suffering.

With the greater role that the community plays in affecting mental health in the bio-psycho-social model, the objective of the treatment itself changes also in the legal framework. If in the Decree mental illness was only an individual concern, in the Act mental disorders are also the result of a maladaptation between the subject and the community of belonging. According to the Act, in fact, *rehabilitating* the individual to be socially competent in his/her social environment and reintegrating him/her into the community is at core of psychiatric treatment. Here are some examples:

> The object of the [Mental Health] Authority is to [...] promote mental health and provide humane care including *treatment and rehabilitation* in a least restrictive environment [...].

> The Minister and the Minister responsible for Social Welfare shall make provision for *psycho-social rehabilitation* and after care services of a patient including supervision, rehabilitation and vocational training. (*Mental Health Act*, 2012; emphasis added)

The rehabilitation of the person with mental disorders is also part of the definitions of "mental health care" and "psychiatry" as conceived by the law in the glossary:

> "mental health care" includes prevention and management of mental disorders and *rehabilitation* of persons with mental disorder
>
> "psychiatry" means a medical discipline concerned with the provision of scientific treatment for mental disorders, *rehabilitation* of persons with mental disorders and the promotion of mental health. (*Mental Health Act*, 2012; emphasis added)

Together with the objective of treatment, in 2012 also the mental health facilities did change. If for the previous forty years the psychiatric hospital was the only place in which mental health services where provided, from 2012 mental health facilities are thought to be smaller centres dispersed in the territory, in order for people to be treated in their own environment and social context (Ramirez, 2018). To achieve this goal, the law promotes the collaboration not only with the already-existing healthcare facilities, but also with the institutions of traditional healers and other alternative medicines:

> To achieve its object, the Authority shall
> [...]
> *(e)* collaborate with other healthcare service providers to ensure the best care of persons with mental disorder;
> [...]
> (m) 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. (*Mental Health Act*, 2012)

Lastly, because the psychiatric hospital is not the only healthcare facility for the treatment of people with mental disorders, the denomination of people under treatment also changes, shifting from "mental patient" to "user" of mental health services. However, in the Act the denomination "patient" is still prevalent.

In a country like Ghana, characterised plural system of resources in which people can find the treatment for their sufferings, being biomedical or "traditional" (Schirripa, 2014), an attempt to merge the different medical realities through collaboration may be fruitful in order for people to exploit both the potentiality of the biomedical system and of the traditional ones. On the other hand, this may also control the latter in order not to leave healers perpetrating the maltreatments we have witnessed so far. Therefore, this may represent one of the strengths of the new Ghanaian mental health law.

CHAPTER IV
CONCLUSIONS

This study relied on the methods of discourse analysis and on the concept of ideology as an epistemological marker to find out which are the words, the categories and the concepts employed in the codification of mental health laws and how these are organised in an ideological whole. We have traced a sort of "ideological map" of mental illness in the governmental documents following the themes that were more redundant and that were not justified in the documents themselves. First, we have seen that the main purpose of mental health laws – ironically – is not the promotion of mental health, but rather the protection of public safety. The documents find their legitimation and justification in the safeguard of the bodily existence of citizens. Accordingly, through mental health law the state can take the freedom of a category of individuals (i.e., the mentally ill) in exchange of the public safety of the majority. Mentally ill people, in this sense, function as a sort of currency.

Secondly, we have analysed how the mentally ill person is constructed in the laws. First of all, it has been highlighted how mental illness in the legal texts does not work like an illness as such; i.e., as a disorder diagnosed by a medical authority. Legally, mental illness acts on the subjects *before* any diagnosis. It acts as a *suspicion*. This is particularly true in cases of "emergency", were mental health laws shows all their coercive potential – even if it is not known what "emergency" means. Indeed, the double face of coercion and compassion has been individuated repeatedly in the documents. This double play acts, for example, in issues like the attribution of competence and capacity to the mentally ill and when the law is concerned with the rights of people with mental disorders.

Perhaps the most "visible" change that the Mental Health Act brought about has to do with the ontological understanding of mental illness. As it has been showed, the shift from an understanding of mental illness focused on the individual to an understanding of mental disorder focused on the interaction between the subject and his/her social milieu

led to a structural adjustment in the architecture of mental health services. Now the aim is to distribute mental health facilities on the national territory, in a way that they could be closer to the users and able to sew up the links between the individual and his/her community that have been disrupted by the occurrence of the mental disorder.

This study has showed how it is possible to read legislative texts "against the grain" in order to let come to the fore – as Apthorpe suggested – the cultural, ideological and moral values that are embedded in the apparently plain, clear and decontextualized rhetoric of legal documents. Such a work can be useful to critically address the legislative instruments, to give a better understanding of them and, ultimately, to ameliorate them. As a way of example, on the basis of the results of this study, it is not difficult to imagine some questions that should be answered in order to overcome the ambiguities of the current law: what if we put mental health, instead of public safety, at the core of mental health law? What if we consider the mentally ill subject on the base of his/her experience of mental suffering, instead of describing *a priori* a mentally ill subject using exclusively legal terms?

Obviously, this study is not devoid of limitations. First of all, the primary sources that exist so far are too few for the results of the analysis to be strongly valid. In fact, having at our disposal policy documents other than the two legislative texts would have resulted in a more accurate and more complex analysis of the ideology of mental health in Ghana. If in the next years the government will publish further mental health policy documents, the results of this research may be corroborated, invalidated or extended. Another limitation is represented by the fact that this analysis is circumscribed to the formal codification of legal documents. But we know that discourses are not formed only by words and papers; they are embedded in the practice of the actors that are performing a particular role within a certain field. Indeed, not only further policy documents may show divergences with the results of this study, but also the way in which the law is implemented on the field can demonstrate discrepancies in this sense.

These limitations suggest at least some line of research that should be undertaken in order to have a better knowledge of mental health policy process and practice in Ghana and to find strategies to solve the numerous problems that policymakers and practitioners are finding on the field. First, it would be useful to analyse not only the governmental documents on mental health policy, but also the policy documents of the single

organizations that are working on the field, like the several NGOs that are involved in mental health issues: their ideology of mental health may differ significantly from the national one and – ultimately – may also have more incisive pragmatic effects. On the other hand, it would be necessary to explore how the daily routine and the experience of mental health professionals and of mental services users has been affected by the enactment of the new law. In short, having an understanding of how mental illness is conceived at the national level can represent a good starting point to formulate new questions and explore new issues related to mental health and illness in the country.

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