

Magnus Mfoafo-M'Carthy and Jeff D Grishow***

Summary

Ghana has recently received much attention for human rights abuses against persons with mental illnesses in traditional 'fetish' and Christian prayer camps. Evidence has surfaced of Ghanaians with mental illnesses being forced against their will to attend the camps only to be physically abused, forcibly isolated and even chained to trees. Not only do these practices reveal a high level of stigma, but they also contravene the spirit and intention of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Despite the fact that Ghana has ratified in the CRPD and passed a new Mental Health Act in 2012, there has been little reaction in the country towards the harsh treatment of patients with mental illnesses at the camps. Lately, however, Ghanaian disability activists have started to take up their cause, protesting the camps as sites of human rights abuses. Starting with the example of one of these activists, also a camp survivor, the article investigates the potential of a human rights framework as a tool for improving the delivery of mental health services in Ghana.

* Associate Professor, Faculty of Social Work and Tshepo Institute for the Study of Contemporary Africa, Wilfrid Laurier University, Waterloo, Canada. This article is part of a larger project funded by the Social Sciences and Humanities Research Council of Canada.

** Associate Professor, Department of History and Tshepo Institute for the Study of Contemporary Africa, Wilfrid Laurier University, Waterloo, Canada.

1 Introduction

In October 2014, the Christian Health Association of Ghana released a film on stigma and mental health to raise awareness about human rights abuses faced by Ghanaians with mental illnesses. The film narrates the story of Doris Appiah Danquah, whose experience with manic depression forced her out of university and into a series of ‘healing’ camps between the late 1970s and early 1990s. In 1978, Danquah earned a place in the Medical School of the Ghana’s premier university, the University of Ghana, after posting top marks at the prestigious Achimota High School in Accra. Her studies did not last long. Shortly after arriving on campus, Danquah began to feel a ‘deep sadness and a deep fear’. She wanted to be alone, skipped classes and struggled mightily as her dream of a medical degree began to slip away. Eventually Doris was diagnosed with manic depression, and her parents realised that she would not be able to complete university without treatment. The University gave her a three-year leave of absence to recover and return to the programme. What followed, however, was 22 years of being moved from institution to institution as Danquah’s family searched in vain for a solution. The first choice was the Accra Psychiatric Hospital, located in the country’s capital. However, the hospital’s psychiatrist turned Doris away, informing her parents that her condition was ‘simply who she was’; that nothing could be done medically; she would never recover, and Doris and her family would have to accept her condition.¹

Desperate to find a cure, Doris’ family tried a series of traditional fetish shrines and Christian prayer camps, believing that her condition had a spiritual cause and that ‘Doris’s depressed soul had escaped from the world of reality and needed to be persuaded back home’.² Doris’s father initially took her to a famous fetish shrine called Akonedi at Larteh in the eastern region of the country. In Larteh, the traditional healers prescribed to Danquah herbs mixed with gin and administered by a caregiver who also helped to dress and bathe her. This placement ended when the caregiver lashed Doris with a belt, catching her eye with the hook, after she had told him that she intended to escape to Accra. Having heard about the beating, Doris’s father moved her to another fetish shrine, the Nana Ntia shrine at Gomoah Fete in the central region.³

This visit also failed and the family moved her to a Christian prayer camp in Kumasi. Treatment at the prayer camp included forced fasting and an ‘intensive routine of prayers and casting away [of] demons’.⁴ Ms

1 DA Danquah ‘Still I arise: The story of Ms Doris Appiah Danquah’ (Christian Health Association of Ghana, 2014), <https://vimeo.com/109473357>, (accessed 1 August 2016).

2 As above.

3 As above.

4 As above.

Danquah recounts that she was beaten by camp officials for challenging the truth of the Bible. When she resisted the beatings, she was chained, for days at a time despite the elements, rain or shine; she was released only to bathe and then chained again. One night, the drunk brother of the pastor came to Ms Danquah and hit her with a gin bottle before shackling her. Camp staff also chained her up after unsuccessful escape attempts. She eventually escaped successfully and found herself roaming the streets. Her family found her and sent her to another prayer camp, this time in a remote area past Zebilla in the northern part of the country. Once again Danquah escaped and, according to her account, she decided to return home and heal herself. Gradually she started feeling better and eventually returned to university, graduating with a nursing degree. Recently, Doris found work as the director of an orphanage, and she acts as a strong advocate for the rights of Ghanaians with mental illnesses.⁵

Doris Danquah claims that she experienced many forms of stigma during her years of involuntary treatment. Many people blamed her for her illness, telling her that the depression was a punishment from God for past wickedness or evil acts. Maybe, others said, she had taken someone's husband or was a witch who killed her children. Whatever the precise belief, she was told that her manic depression was a divine punishment for her sins because she 'didn't serve God well'.⁶ When she found herself alone on the streets, some people gave her food or money but still expressed deep prejudices. In one example, Ms Danquah recounted that some children gave her a few coins to buy food but threw the plate into a fire after she had finished eating. This seemed to have been a common practice, and Ghanaian psychiatrist Dr Gordon Donnir, who was interviewed along with Danquah in 2014, attributes this to the belief that mental illness is contagious and can be transmitted through direct contact with the 'infected' person. In Dr Donnir's opinion, these actions show that individuals diagnosed with a mental illness are the most stigmatised of any disabled group in Ghana.⁷

What should we make of Doris Danquah's narrative in *Still I arise*?⁸ As Nepveux and Beitics observe, there is a tendency for disability documentaries to present Western, neo-colonial narratives of disability that portray disabled Africans as inferior, passive and in need of Western charitable interventions.⁹ This is certainly the case in the two films they study – *Emmanuel's gift* (Ghana) and *Moja Moja* (Kenya) – and it certainly could be true of African-produced films such as *Still I arise* as Ghanaian perspectives such as Danquah's could be influenced by charitable/neo-

⁵ As above.

⁶ As above.

⁷ As above.

⁸ Danquah (n 1 above).

⁹ D Nepveux & E Smith Beitics 'Producing African disability through documentary film: Emmanuel's Gift and Moja Moja' (2010) 4 *Journal of Literary and Cultural Disability Studies* 237-238 251-253.

colonial models and assumptions about disability. Nevertheless, we argue that *Still I arise* (Ms Danquah's story) is different in its emphasis on agency and personal efforts to free oneself from discrimination and stigma through self-healing. This is a story of the strength, perseverance and tenacity of a disabled individual, who takes back power after it was taken from her. It is also a story of rights, in that Ms Danquah talks openly about the violation of human rights in the prayer camps and (to a lesser extent) fetish shrines, and the need to enhance disability rights by changing attitudes towards disabled Ghanaians. In its insistence on rights for persons with mental illnesses as a precursor for self-healing and self-determination, Danquah's story hits on the core debates over the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) and mental health, and offers an excellent springboard for assessing the potential of the CRPD in light of Ghanaian conditions. First, however, we must address the issue of the validity of Danquah's claims.

2 Disability, mental illness and stigma in Ghana

Are Ms Danquah's claims valid in light of what we know about the prevalence and causes of stigma towards persons with mental illnesses in Ghana? Answering this for Ghana is complicated by the fact that many foreign non-governmental organisations (NGOs) and media outlets portray many African countries – and Africa generally – as particularly prone to stigma towards disability. Following Ahmedani, we define stigma with reference to Goffman and Dudley, whose definitions of stigma include attitudes that discredit individuals and discount their identities, as well as stereotypes that portray individuals or groups as inferior against societal norms.¹⁰ Using this definition, many popular reports paint a picture of Africa generally as particularly prone to stigma against disabled persons. At best, attitudes of stigmatising result in disabled persons being denied access to health care and education. At worst, they are hidden, locked away, abandoned or even killed. While the popular literature tends to make such pronouncements without solid evidence,¹¹ the weight of recent scholarly research – stimulated by the Movement for Global Mental Health launched in 2007¹² – does point to widespread stigma in Africa.

¹⁰ E Goffman *Stigma: Notes on the management of spoiled identity* (1963) 2-6; JR Dudley 'Confronting stigma within the services system' (2000) 45 *Social Work* 1; BK Ahmedani 'Mental health stigma: Society, individuals, and the profession' (2011) 8 *Journal of Social Work Values and Ethics* 2.

¹¹ There are many reports making claims of disability stigma in Africa, often backed up by no real evidence. See eg Plan Togo <https://plan-international.org/where-we-work/africa/togo/about-plan/news/reducing-the-stigma-around-children-with-disabilities-in-togo/>; Advantage Africa <http://www.advantageafrica.org/topics>; Inclusion International <http://inclusion-international.org/inclusion-africa-2/>; Integrated Regional Information Networks (IRIN) <http://www.irinnews.org/report/90139/senegal-children-with-disability-when-stigma-means-abandonment>; VOA News 19 June 2012 <http://www.voanews.com/content/the-curse-of-childhood-disability-in-south-africa/1213185.html> (all websites accessed 20 September 2016).

¹² <http://www.globalmentalhealth.org> (accessed 1 September 2016).

This research represents a significant shift in opinion over the past decade. Previously, many commentators assumed that stigma towards mental illness was low in Africa compared to that in other parts of the world. This perception was reinforced by a lack of research into stigma and mental illness in Africa. A survey of existing research conducted in 2006 found only 62 publications worldwide between 1990 and 2004 on beliefs and attitudes towards mental illness. The vast majority focused on European countries, and Ethiopia was the only African country on the list, represented by a single study on the north-western part of the country published in 1999.¹³ Since 2004 many more academic studies have appeared, most likely connected to the advocacy efforts of the Movement for Global Mental Health mentioned above. The more recent work has found evidence of widespread stigma towards mental illness in Africa. For example, researchers have found unexpected high levels of stigma towards persons with mental illnesses among Nigerian clergy and university students, towards persons with psychotic illnesses in South Africa, and in primary schools in Kenya.¹⁴ On a comparative level, one study concluded that stigma towards mental illness was worse in Cameroon than in Canada.¹⁵

In Ghana, a recent study of disability in Accra reveals evidence of widespread discrimination and stigma towards disabled Ghanaians generally, who are among 'Ghana's most excluded members of society'.¹⁶ Recent literature on mental illness in Ghana presents a similar picture of high levels of stigma, on four levels: within the family; in public settings; at the workplace; and among health service providers. At the family level, academic research points to high levels of discrimination and stigmatisation against family members with mental illnesses. In the community of Pantang in Accra, Dako-Gyeke and Asumang found that most of the patients had been deserted by their families (spouses, parents and children, among others), beaten up, molested, labelled as witches and accused of causing their own predicaments. They further found that if

- 13 MC Angermeyer & S Dietrich 'Public beliefs about and attitudes towards people with mental illness: A review of population studies' (2006) 113 *Acta Psychiatrica Scandinavia* 169.
- 14 AO Adewuya & ROA Makanjuola 'Social distance towards people with mental illness amongst Nigerian university students' (2005) 40 *Social Psychiatry and Psychiatric Epidemiology* 868; AO Adewuya & ROA Makanjuola 'Social distance towards people with mental illness in Southwestern Nigeria' (2008) 48 *Australian and New Zealand Journal of Psychiatry* 394; NG Igbinomwanhia & JO Omoaregba 'The attitudes of clergy in Benin City, Nigeria towards persons with mental Illness' (2013) 16 *African Journal of Psychiatry* 200; CO Egbe 'Experiences and effects of psychiatric stigma: Monologues of the stigmatizers and the stigmatized in an African setting' (2015) 10 *International Journal of Qualitative Studies on Health and Well-Being* 6-7; DM Ndetei et al 'Stigmatizing attitudes toward mental illness among primary school children in Kenya' (2016) 51 *Social Psychiatry and Psychiatric Epidemiology* 79.
- 15 KO St Louis & PM Roberts 'Public attitudes toward mental illness in Africa and North America' (2013) 16 *African Journal of Psychiatry* 131.
- 16 KL Geurts & SGMA Komabu-Pompeyie 'From "sensing disability" to *Seselelame*: Non-dualistic activist orientations in twenty-first century Accra' in S Grech & K Soldatic (eds) *Disability in the global south: The critical handbook* (2016) 295.

persons with mental illnesses were parents, their family members denied them access to their children on the grounds that the parents were dangerous and might harm the children.¹⁷ These findings have been corroborated by other research. In a study and focused on the three main psychiatric hospitals in Ghana (Pantang, Accra and Cape Coast), Barke et al found that mental health patients were discriminated against and stigmatised by their families, as some participants asserted that they did not feel comfortable living with persons with mental illnesses or who had a history of mental disorders. Among other things, participants claimed that the behaviour of mental patients was never predictable and, as such, they were dangerous and potentially harmful to family members.¹⁸

In a study in Ho in the Volta region, Tawiah found that people with mental health issues were discriminated against and stigmatised at the economic, social and psychological levels within their family settings. At the economic level, family members denied food and the basic necessities of life to relatives with mental disorders. This psychologically impacted them as it affected their self-esteem. Socially, some family members hid relatives with mental illnesses from the public, and verbally abused, ridiculed and mocked them at home.¹⁹ The consequences of the above types of abuse in family settings are devastating to the healing processes of Ghanaians with mental illnesses. At the very points where they need the most moral, social, financial and physical support, those who should be the most supportive tend to either abuse them or simply abandon them to their fate. As a result, mental patients always feel isolated and distant from their loved ones, and they develop a low self-esteem.²⁰ At the other end of the spectrum, several studies have found that some families discriminate against family members with mental illnesses through overprotection and excessive sympathy. For example, Thornicroft et al found that, even though family members of mental patients were supportive, the patients sometimes felt they were being overprotected and not given their independence to do certain things.²¹ Barke et al found that some members displayed an excess of sympathy to relatives with mental disorders. As with overprotection, 'over-sympathy' negatively affected the self-determination of Ghanaians with mental illnesses, often by blocking efforts to help them overcome or cope with their conditions. In many

- 17 M Dako-Gyeke & ES Asumang 'Stigmatization and discrimination experiences of persons with mental illness: Insights from a qualitative study in Southern Ghana' (2013) 11 *Social Work and Society International Online Journal* 5-8.
- 18 A Barke et al 'The stigma of mental illness in Southern Ghana: Attitudes of the urban population and patients' views' (2011) 46 *Social Psychiatry and Psychiatric Epidemiology* 1196-1198.
- 19 PE Tawiah 'Stigma and discriminations suffered by mental patients and their caregivers in the Ho municipality of Ghana' unpublished PhD thesis, University of Ghana, 2012 28-29.
- 20 Dako-Gyeke & Asumang (n 17 above) 5-6.
- 21 G Thornicroft et al 'Discrimination in health care against people with mental illness' (2007) 19 *International Review of Psychiatry* 113-114.

cases, excessive sympathy took the guise of pity and a lack of respect for family members with mental illnesses.²²

At the societal level, studies have found that it is usually the friends and neighbours of persons with mental illnesses who act in degrading ways towards them and, hence, reproduce discrimination and stigmatisation on a wider basis. For example, Barke et al reported that some participants wanted mental patients to be sent away and isolated from their communities or, at the very least, they refused to live nextdoor to someone known to suffer from a mental illness.²³ Dako-Gyeke and Asumang as well as Tawiah confirmed this finding when they discovered that persons with mental illnesses were deserted and shunned by their friends and neighbours. They also found a widespread aversion to marrying people with or who had a history of mental illness. When asked why they harboured these feelings, respondents across several studies accused mental patients of being harmful, dangerous and unpredictable in their behaviour.²⁴

Apart from the fact that people wished them to be isolated from general society or avoided their company, persons with a history of mental illness were also ridiculed and removed from groups or associations they initially belonged to before falling ill. For instance, a Ghanaian woman with a mental illness interviewed by Thornicroft et al said:

I used to be very influential in the local community, I was chair of the Education Committee, but I discovered that they don't involve me so much anymore ... I used to socialise in my community, then they would be looking at me in a funny way and for a couple of them, it's like you don't exist anymore.²⁵

Of the many community institutions, one might expect that formal churches or other religious organisations – as opposed to prayer camps – would be part of the public sphere where persons with mental illnesses would be embraced more warmly. However, the research that has been done suggests otherwise. For example, Thornicroft et al found that religious institutions also stigmatised and discriminated against their members with mental illnesses. One participant revealed that after she had narrated her ordeal to her church members as a form of testimony, they withdrew themselves from her, and she later regretted testifying to her church members because of the way they reacted towards her.²⁶

Perhaps worse than being removed from or shunned by civic associations, Dako-Gyeke and Asumang also found that that publicly-

22 Barke et al (n 18 above) 1196.

23 As above.

24 Dako-Gyeke & Asumang (n 17 above) 6; Tawiah (n 19 above) 28-29.

25 Thornicroft et al (n 21 above) 113.

26 Thornicroft et al 114.

identified mental health patients were labelled with derogatory language ('crazy,' 'lunatics', and so forth), and were often left to beg for food along the streets of urban centres in order to survive.²⁷ When people begin to label mental health patients as lunatics, mad or crazy, what is meant is that they are of no use to society any longer. However, the fact is that mental illness can be treated, and those who are suffering could be made responsible and their condition restored if people regard them the same as any other person suffering any other form of illness. However, because of negative public attitudes towards persons with mental illnesses, most mental health patients do not want to be known publicly and, thus, do not seek medical treatment from formal health institutions. Instead, stigma and discrimination often drive Ghanaians with mental illnesses to prayer camps and traditional healers for treatment.²⁸

Ghanaians with mental illnesses are also discriminated against and stigmatised in the workplace by prospective or current employers and colleagues. Employers often refuse to hire individuals with mental illnesses. That this practice may be common is illustrated by Barkeet al, whose recent study reported that 77.2 per cent of mental health patients asserted that most employers will pass over their applications in favour of other candidates without mental health problems.²⁹ In other cases, respondents reported about being dismissed by employers if they developed a mental illness after having been hired. Some employers also admitted to believing that they would lose customers if they employed individuals with visible or known mental illnesses.³⁰ In addition to not being hired or being dismissed, Thornicroft et al reported that some employers would reduce the number of hours or days worked by employees with mental illnesses, although the respondents were not sure whether the employers did so because of discrimination or because they believed that it was for the good of the employee.³¹ At least one study added a gender dimension to workplace stigmatisation, finding that women reported more cases of discrimination than their male counterparts.³² In addition, multiple studies have revealed that co-workers as well as employers routinely stigmatised and discriminated against persons with mental illnesses. This includes general levels of discomfort working alongside a colleague considered to have a mental illness, as well as more active forms of stigmatisation in the form of humorous, degrading and derogatory comments, and accusations that a co-worker with a mental illness may be dangerous and cause harm to others.³³

27 Dako-Gyeke & Asumang (n 17 above) 8.

28 UM Read et al 'Local suffering and the global discourse of mental health and human rights: An ethnographic study of responses to mental illness in rural Ghana' (2009) 5 *Globalization and Health* 4 9; Tawiah (n 19 above) 26.

29 Barke et al (n 18 above) 1198.

30 Dako-Gyeke & Asumang (n 17 above) 9-10.

31 Thornicroft et al (n 21 above) 114.

32 Tawiah (n 19 above) 25.

33 Dako-Gyeke & Asumang (n 17 above) 6; Tawiah (n 19 above) 28-29.

The final level at which discrimination and stigmatisation take place is that of health service providers in both formal and informal settings. According to Human Rights Watch, health service providers discriminate against and stigmatise Ghanaians with mental illnesses by denying them food and medicine, refusing to provide them with adequate shelter, subjecting them to involuntary treatment, and physically abusing them in cruel, inhuman and degrading ways.³⁴ This corroborates with the findings of Thornicroft et al, who found one of their participants asserting that she had been forcibly held by a group of health personnel and given an injection against her will.³⁵ Human Rights Watch also established that nurses at times verbally abused and physically inflicted pain on patients with mental illnesses, especially when they were ‘trying to escape, when they complained about pain, and when they failed to take medication, or for failing to follow hospital rules’.³⁶ Ghanaians with mental illnesses are treated in this way whereas others, such as malaria patients, are not, because persons with mental illnesses are stigmatised in the sense of being labelled and stereotyped as inferior or dangerous.

A common thread running through popular reports and academic studies on stigma in Ghana is the idea that mental illness is caused by supernatural forces. For instance, the BBC reported in 2010 that an increasing number of disabled African children were being accused of witchcraft.³⁷ Similarly, as part of a special series on children in South Africa, *Voice of America News* claimed that children with cerebral palsy were considered by some Xhosa families to be ‘bewitched’ by bad spirits.³⁸ More recently, the *Huffington Post* claimed:

The most frequently-stated causes of disability in Uganda and Africa at large include witchcraft; a curse or punishment from ‘gods’, anger of ancestral spirits, bad omens, reincarnation, heredity, incestuous relationships, and the misdeemeanors of the mother. These misperceptions not only lead to stigma, but also to a belief that children with disabilities should be demonised.³⁹

NGO reports paint a similar picture. In a four-country survey, for example, Plan International stated that respondents from Togo, Sierra Leone, Niger

³⁴ Human Rights Watch ‘Like a Death Sentence’: *Abuses against persons with mental disabilities in Ghana* (2012) 17.

³⁵ Thornicroft et al (n 21 above) 114.

³⁶ Human Rights Watch (n 34 above) 17.

³⁷ British Broadcasting Corporation ‘Rise in African children accused of witchcraft’ (2010) <http://www.bbc.com/news/world-africa-10671790> (accessed 20 September 2016).

³⁸ Voice of American News ‘African children struggle with poor health care’ 2012 19 <http://www.voanews.com/content/the-curse-of-childhood-disability-in-south-africa/1213185.html> (accessed 20 September 2016).

³⁹ TK Davenock ‘Not all disabled are created equal’ *Huffington Post* 2015 http://www.huffingtonpost.com/tarita-karsangi-davenock/not-all-disabled-are-created-equal_b_8374510.html (accessed 20 September 2016).

and Guinea commonly said that mental illness often was ‘inflicted due to a “bad spirit”’, or was ‘a curse from God’.⁴⁰ In Ghana, an oft-quoted report by Human Rights Watch states that ‘disability is widely considered – even by persons with mental disabilities themselves – as being caused by evil spirits or demons’. As such, casting out evil spirits is an important part of the cure, and fasting in prayer camps is believed to facilitate this process.⁴¹ Ghanaian beliefs in spiritual causes of mental illness have been confirmed by systematic academic studies. For example, a team led by the respected disability scholar Ursula Read reported that many of the 67 interviewees – including persons with mental illnesses – attributed the illnesses to ‘evil spirits, sorcery and witchcraft’.⁴² These beliefs, combined with the pervasiveness of discrimination and stigma within the family, in public, at the workplace and among health service providers, result in family members often forcing Ghanaians with mental illnesses to attend fetish shrines or prayer camps for treatment.⁴³

3 CRPD and mental health

It is in the above contexts that we should consider the potential of the CRPD as a tool for combatting human rights abuses towards Ghanaians with mental illnesses. Opened for ratification in 2006, the CRPD has transformed the discussion of global disability and focused attention on human rights for disabled individuals in the majority world.⁴⁴ The champions of the CRPD are very optimistic about its potential, claiming that the Convention has produced ‘a paradigm shift in political conceptions of disability’,⁴⁵ which has triggered a new disability discourse capable of empowering civil society,⁴⁶ in turn making it possible to ‘legislate a belief change regarding persons with disabilities’.⁴⁷ One optimist goes as far as writing that the CRPD will lead to the removal of ‘societal barriers that create and reinforce disability’.⁴⁸ Others are not convinced. Pointing to the African context, Lang and Groce and their

40 S Coe *Outside the circle: A research initiative by Plan International into the rights of children with disabilities to education and protection in West Africa* (2013) 24.

41 Human Rights Watch (n 34 above) 7 16 17 26.

42 Read (n 28 above) 7.

43 Tawiah (n 19 above) 23.

44 ‘Majority World’ is the latest and arguably most accurate label for the world region formerly labelled ‘Third World’, ‘Developing World’ and/or ‘Global South’. C Barnes & A Sheldon ‘Disability, politics and poverty in a majority world context’ (2010) 25 *Disability and Society* 771–772.

45 H Mannan et al ‘Core concepts of human rights and inclusion of vulnerable groups in the United Nations Convention on the Rights of Persons with Disabilities’ 2012 6 *ALTER – European Journal of Disability Research* 172.

46 P Harpur ‘Embracing the new disability rights paradigm: The importance of the Convention on the Rights of Persons with Disabilities’ (2012) 27 *Disability and Society* 1.

47 MA Stein & JE Lord ‘Future prospects for the United Nations Convention on the Rights of Persons with Disabilities’ in MA Oddny & G Quinn (eds) *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian perspectives* (2009) 32.

48 DS Cobley ‘Towards economic participation: Examining the impact of the Convention on the Rights of Persons with Disabilities in India’ (2013) 28 *Disability and Society* 453.

colleagues have found that successful implementation has been hampered in Nigeria, Zimbabwe and Uganda by problems of governance (inadequate national disability laws, limited political will) and weaknesses within DPOs (underfunding, overwork, control by paternalistic urban elites). This is particularly disturbing because, to secure their rights, disabled individuals require more resources and support than non-disabled persons.⁴⁹ Similar problems have been identified in South Africa, Kenya and Ghana.⁵⁰ The problem is compounded when disabled persons lack the power, money and/or education to claim their rights.⁵¹ If this is the case, ‘rights can do nothing but reinforce the status quo, as those left powerless can do nothing [but] make sporadic and/or symbolic claims’.⁵² By implication, unless a disabled individual gains support from a more powerful and/or wealthy patron, or perhaps moves up the social ladder, a rights-based approach actually may reproduce the marginalisation of disabled individuals in the majority world.⁵³ This effect may be worsened if communities in majority world settings have different conceptions of practices that Western law makers consider to be human rights abuses.⁵⁴ As we shall see below, the majority world beliefs about human rights – and in our case Ghanaian beliefs specifically – are especially applicable to questions about mental illness.

Of the CRPD’s provisions, article 12 (mental capacity), article 14 (equality of liberty and security) and article 17 (physical and psychological integrity) relate most directly to mental health. As with the CRPD generally, these articles reflect the participation of DPOs in the drafting process. As a result, the CRPD privileges ‘the values, preferences and life projects of (disabled persons)’ and seeks to reorient legal regimes with this goal in mind.⁵⁵

- 49 R Lang et al ‘Implementing the United Nations Convention on the Rights of Persons with Disabilities: Principles, implications, practice and limitations’ (2011) 5 *ALTER – European Journal of Disability Research* 208-211; see also CJ Eleweke ‘A review of the challenges of achieving the goals in the African Plan of Action for People with Disabilities in Nigeria’ (2013) 28 *Disability and Society* 316-322.
- 50 M Heap et al “‘We’ve moved away from disability as a health issue; it’s a human rights issue”: Reflecting on 10 years of the right to equality in South Africa’ (2009) *Disability and Society* 858-859; BM Opini ‘A review of the participation of disabled persons in the labour force: The Kenyan context’ (2010) 25 *Disability and Society*; DM Nepveux ‘Reclaiming agency, ensuring survival: Disabled Urban Ghanaian Women’s Negotiations of Church and Family Belonging’ (2006) 26 *Disability Studies Quarterly* [no pagination]; M Ssengooba et al “‘Like a death sentence”: Abuses against persons with mental disabilities in Ghana’ Human Rights Watch Report 2012 82-83.
- 51 M Russell ‘What disability civil rights cannot do: Employment and political economy’ (2002) 17 *Disability and Society* 129.
- 52 DA Young & R Quibell ‘Why rights are never enough’ (2000) 15 *Disability and Society* 122.
- 53 R Malhotra ‘Expanding the frontiers of justice: Reflections on the theory of capabilities, disability rights, and the politics of global inequality’ (2008) 22 *Socialism and Democracy* 96-97.
- 54 Read et al 11-12.
- 55 S Wildeman ‘Protecting rights and building capacities: Challenges to global mental health policy in light of the Convention on the Rights of Persons with Disabilities’ (2013) 41 *Journal of Law, Medicine and Ethics* 58.

This approach rejects the medical model of disability put forward by non-disabled medical experts, which defines disability as an impairment and takes a charitable approach towards interventions designed to ‘normalise’ disabled bodies. In its place, the CRPD shifts the ground to the social model, which argues that disability is socially constructed by non-disabled actors. As expressed in the CRPD, the social model emphasises autonomy and self-determination in the pursuit of disability rights.⁵⁶ In relation to mental health, this priority informed the drafting of articles 12, 14 and 17 but, as we shall see, the drafting process was contentious and the results were ambiguous and not unproblematic.

Article 12 sets out the right of disabled persons to play an active role in decisions affecting their well-being. The article takes a very strong stance against substitute decision making, in which a person assumes decision making for another person without their consent. However, it permits supported decision making, whereby a person permits someone else to make their decisions, so long as safeguards are put into place to ensure true participation and consent in decision making.⁵⁷ However, the article does not set out how this may be achieved in practice, and there are no mechanisms to monitor safeguards or adjudicate disputes between disabled persons and the decision makers should they arise. Article 14 guarantees equality of liberty and security, including protection from arbitrary detention. According to this article, any form of detention solely based on disability without the consent of the disabled person is prohibited.⁵⁸ However, article 14 does not preclude preventive detention on other grounds, such as danger, if it is ‘de-linked’ from disability, and some governments, including that of Britain, have argued that preventive detention does not violate article 14 if it is justified by the risk posed to the disabled person or their community.⁵⁹ Article 17 sets out the right to ‘physical and psychological integrity’, which includes protection from compulsory medical treatment. However, it is very brief (only 23 words in total) because of disagreements and a lack of consensus during the drafting process. As a result, governments can (and have) argued that the CRPD allows for compulsory treatment as long as it does not include ‘torture or inhuman or degrading treatment’.⁶⁰ While the UN Office of the High Commissioner for Human Rights (OHCHR) and the CRPD Committee disagree with this interpretation, it is nonetheless possible for governments to make the case.⁶¹

This brief discussion of articles 12, 14 and 17 raises several questions about the CRPD, mental health and disability rights. In the weakest case,

56 Wildeman (n 55 above) 59.

57 Wildeman 56–58.

58 P Bartlett ‘The United Nations Convention on the Rights of Persons with Disabilities and mental health law’ 2012 75 *Modern Law Review* 767–768.

59 Bartlett (n 58 above) 772 775.

60 Bartlett 756.

61 Wildeman (n 55 above) 57.

the CRPD leaves much room for interpretation, and its provisions related to mental health have been challenged by governments in the West, including those of Australia and Canada. In the strongest case, the CRPD calls for autonomy and self-determination for persons with mental illnesses and an end to involuntary treatment, coercive physical punishment and substitute decision making. But even the strongest case requires certain prerequisites, especially sufficient access to the resources needed to support decision making and autonomy. The Implementation Manual for the CRPD drafted by the World Network of Users and Survivors of Psychiatry (WNUSP) sums this up as follows:

Autonomy and self-determination are dependent on having sufficient access to resources so that economic and social coercion do not lead to decision making that does not reflect the person's own values and feelings ... Autonomy and self-determination are also dependent on the existence of meaningful alternatives related to the particular decision at issue.⁶²

Through their participation in the process of drafting the CRPD, persons with psychosocial and intellectual disabilities have introduced, in Wildeman's words, 'the emancipatory project of shifting mental health policy from its historical fixation on involuntariness and incapacity toward the relatively uncharted territory of supports'.⁶³ Wildeman supports this position in calling for the creation of 'supportive social systems (including access to material resources and a range of meaningful options)', which she believes 'are essential to the development and expression of autonomy'.⁶⁴ The reference to 'material resources' is consistent with the argument by the creators of the social model that economic development is a necessary precursor for disability rights. This, as we shall see in the next section, complicates the discussion of mental health rights in the Ghanaian context.

4 CRPD, mental health and Ghana

Against critics who dismiss the CRPD's approach as 'fantastical extensions of the social model to the point of denying the phenomenon of impairment', Wildeman argues that international agencies should use the CRPD as a basis for investigating the social supports required for achieving 'autonomy and active citizenship' based on the perspectives of

persons with psychosocial disabilities and also those with intellectual disabilities – including persons with direct experience of capacity determination or coercive interventions – across different cultural, social, and

62 Quoted in Wildeman (n 55 above) 59.

63 Wildeman (n 55 above) 60.

64 Wildeman 59.

national locations and across intersecting categories of discrimination including race, gender, and age.⁶⁵

Doris Danquah is one such person with direct experience of forcible confinement and involuntary treatment. As such, as Wildeman would argue, we should heed Danquah's call to confront human rights abuses at fetish shrines and prayer camps. At the national level, the first step would be for the Ghanaian government to rewrite its Mental Health Act to make it consistent with the CRPD's call for autonomy and self-determination. Interestingly, in 2012, the year in which Ghana ratified the CRPD, the Ghanaian government did pass a revision to its 1972 Mental Health Act. The 2012 Act addresses human rights, but it continues to permit involuntary treatment and substitute decision making. According to article 42, a third party may apply to a court to admit a person with a mental illness against their will, if there is a risk of self-harm or harm to others, or if it is believed that their condition will deteriorate significantly. Patients can be admitted either to an accredited facility under the Health Institutions and Facilities Act of 2011, or to an institution recognised by the Minister of Health.⁶⁶

The current Ghanaian Health Act clearly contravenes the spirit and intention of the CRPD. As a first, step, therefore, it would be reasonable to pressurise the government to revise the Act accordingly. This would at least provide a foundation for mental health advocates, such as Doris Danquah, to lobby for choice of treatment. However, even if the Ghanaian government were to change the Act, achieving the CRPD's ideals of self-determination and autonomy for persons with mental illnesses would face significant challenges. In the short term, it appears that the Ghanaian government is willing to collaborate with fetish priests and prayer camp leaders in the delivery of mental health care.⁶⁷ If this practice takes root, the fetish and prayer camps will remain part of the country's informal system of delivering mental health services, which – in light of the current Mental Health Act – would keep the door open to involuntary admissions without the consent of Ghanaians with mental illnesses. As such, activists, NGOs and other lobbyists could promote human rights and attempt to change attitudes. Some scholars appear to believe that this might be the best way forward, arguing that shrines and prayer camps can treat patients effectively if their leaders are taught to eliminate forcible confinement and abusive behaviour.⁶⁸ However, there is some evidence that many Ghanaians with mental illnesses accept the necessity of forcible confinement, including chaining, as a result of moral beliefs that place

65 Wildeman 60.

66 Secs 18 & 22 Ghana Mental Health Act 846 of 2012.

67 D Arias et al 'Prayer camps and biomedical care in Ghana: Is collaboration in mental health care possible?' (2016) 11 *PLoS ONE* 2-3.

68 A de-Graft Atkins 'Mental illness and destitution in Africa: A social-psychological perspective' in E Akyeampong et al (eds) *The culture of mental illness and psychiatric practice in Africa* (2015) 134-135 138.

community needs above individual needs.⁶⁹ Changing beliefs, therefore, might pose a formidable challenge in the short term.

As a long-term solution, social model advocates argue that economic development and equitable distribution of its proceeds are necessary precursors to disability rights, especially in the majority world.⁷⁰ This idea is present in the CRPD and it is implicit in the WNUSP's belief – quoted above – that persons with mental illnesses must have access to enough resources to eliminate 'economic and social coercion' that may force them to make decisions against their will.⁷¹ But would economic development automatically produce changes in culture and attitudes? This is a difficult question to answer. Current attitudes in Ghana towards mental illness and fetish shrines and prayer camps certainly are rooted in culture and society. But rather than being 'traditional' in the sense of having existed since time immemorial, they are instead rooted in historical changes connected to colonialism, development and modernity. During the colonial era 'witchcraft' and 'fetish cults' blossomed in Ghana in the context of the country's uneven integration into the world economic system. The Akonedi shrine, for example, where Doris Danquah spent her first episode of involuntary confinement, dates to the mid-1800s and emerged as an important healing shrine only during the leadership of the shrine priestess, Nana Ama Ansaa, between 1927 and 1957.⁷² More obviously, Christian prophets date from colonial times, and they were connected to anti-witchcraft campaigns from the 1920s and 1930s. The preoccupation with witchcraft continued after independence and escalated with the boom in evangelical churches since the 1980s.⁷³ As such, these beliefs are not traditional in the sense of being timeless. Indeed, present forms of culturally-based stigma and discrimination towards persons with mental illnesses (and other disabilities) in Ghana are not mere primordial relics of an ancient past. On the contrary, they are expressions of Africa's uneven development and incorporation into the modern world. African cultural institutions and norms are not static, but instead have shifted and transformed over time in response to the challenges posed by uneven development, poverty, eroding social services and threats to community social cohesion. The lesson here is that, in order to nurture attitude changes, economic growth is not only necessary in a general sense, but it must be equitable as well as robust, reaching into rural areas and down to the village and community level.

69 Read et al (n 28 above) 10-12.

70 Barnes & Sheldon (n 44 above) 778-779.

71 Quoted in Wildeman (n 55 above) 59.

72 OA Boakyewa 'Nana Oparebea and the Akonnedi Shrine: Cultural, religious and global agents' unpublished PhD thesis, Indiana University, 2014 48-49.

73 P Gifford 'A View of Ghana's new Christianity' in L Sanneh & JA Carpenter (eds) *The changing face of Christianity: Africa, the West, and the world* (2005) 84-85; TC McCaskie 'Anti-witchcraft cults in Asante: An essay in the social history of an African people' (1981) 8 *History in Africa* 137-138.

5 Conclusion

Numerous factors contribute to the stigmatisation of mental illness in Ghana. One problem is the cultural myth that attributes mental illness to curses, or the visitation of the sins of one's forefathers, or other forms of personal weakness. These beliefs justify the shunning of the victims and their treatment as second-class citizens. It also explains why people such as Doris Appiah Danquah are sometimes sent to consult fetishes or subjected to abuses in spiritual camps. Clearly, these practices have cultural foundations, and attitudes need to change. Some NGOs, such as Plan Togo, have initiated programmes towards this end. They believe that sensitisation is the key to ending stigma towards disabled persons, and this organisation is working to help parents and children to raise awareness of how important it is to integrate children with disabilities into education and the community.⁷⁴

However, is it enough to simply focus on educating and convincing non-disabled persons to shift their attitudes towards mental illness? Our analysis suggests that it is not. Instead, one should search for the underlying roots of these attitudes. In the case of Ghana, these roots are not simply traditional but rather tied to the country's historical experience with development and modernity, which has produced or strengthened certain 'traditional' narratives as opposed to others. In this sense, disability is socially constructed on the foundation of economic roots. Prior to or along with programmes to change attitudes, there must be programmes to deliver equitable economic growth in general, including growth for the non-disabled population and development that provides disabled persons with opportunities for productive activities, if they so choose. If this can be achieved, then disabled Ghanaians – including those with mental illness – might have more opportunities for social inclusion and more power for self-advocacy. In the long term, this could provide a basis for changing attitudes towards mental illness, including the attitudes of the leaders of fetish shrines and prayer camps.

Perhaps more importantly, in the short and medium term proceeds from growth and development should be directed to social supports, including programmes to strengthen the state's capacity to recruit medical professionals and deliver social services. This addresses a second problem related to overcoming stigma towards mental illness in Ghana: the lack of psychosocial approaches to treatment. Ghana's mental health system is overly dependent on medication, which can negate the effective treatment of persons with mental illnesses. But even where medicines are effective, Ghana's lack of psychiatrists and shortage of antipsychotic and

⁷⁴ Plan Togo <https://plan-international.org/where-we-work/africa/togo/about-plan/news/reducing-the-stigma-around-children-with-disabilities-in-togo/> (accessed 20 April 2015).

psychotropic medications severely limit treatment options. As a result, the psychiatric hospitals are severely overcrowded and families are forced to explore alternative treatment through fetish shrines and prayer camps. In light of this situation, we believe that improving economic conditions and the capacity of the state to deliver medical services are necessary foundations for changing attitudes to reduce stigma. It is not a question of simply altering supposed traditions of stigma, discrimination and social exclusion.

The situation seems dire, but new developments in disability rights have allowed disabled activists to begin to combat stigmatisation and discrimination. After 22 years, Doris Danquah was able to go back to university to complete a nursing degree. She is now a strong advocate for the rights of persons with mental illnesses and, along with other activists, she is working to change social norms and public policies. Her story deserves a wide audience. She and other disabled Ghanaians need to be supported by changes in the material conditions of their societies. Economic growth, better social service provision and incentives to recruit more medical professionals would be a very good starting point.