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It takes a village: what lessons can the UK learn from rural community mental health services in Ghana?

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It takes a village: what lessons can the UK learn from rural community mental health services in Ghana?

Abstract

***Purpose**:* This paper aims to provide new insights and offer potential solutions to the challenges encountered by mental health services working with remote, rural or underserved communities in the UK.

***Approach**:* In this paper, we reflect on the utility of integrating conventional clinical approaches, with preventive care and empowering work within the community, to provide culturally sensitive and accessible mental health services. We describe an example of community intervention from a mental health service in Ghana designed to enhance reach within remote and rural communities and identify potential lessons for practice in the UK.

***Findings**:* The partnership between community mental health services and the rural communities, including families and existing social frameworks, applies collaborative care to overcome the *lack of resources* and facilitate the *acceptability* of mental health services to the local population. There are a series of important lessons from this experience including the importance of understanding the culture of a community to optimise reach and the importance of working IN the community and WITH the community.

***Originality**:* This paper is novel because it provides learning from a model of care applied in the global south that has potential for implementation with underserved populations in the UK. We suggest a reframing of the notion of community care to encompass existing frameworks of community, not merely a biomedical conceptualisation.

Key words: Rural communities; Mental health care; Cultural sensitivity; inequality; Global South

Introduction

Access to mental health services in rural areas is a long-standing and longitudinal issue worldwide (Morales *et al*., 2020; Perkins *et al*., 2013). This is partially due to the geographic and structural characteristics of rural areas that constrain the provision of health services (Fitzpatrick *et al*., 2017) but a number of other barriers have been identified relating to access to mental health services. Bischoff *et al*. (2013) outline two particular challenges to providing mental health services in rural areas: *availability* of mental health resources; and the population's *acceptability* of and willingness to access the resources. With the former, they indicate that rural and remote areas are characterised by fewer mental health services which are often concentrated in areas of high population. Access to services is limited due to

a lack of facilities and professionals to deliver services (Morales *et al*., 2020; Sharma, 2020) but also due to factors such as limited public transport (Del Rio *et al*., 2017; Berg and Ihlström, 2019).

However, Bischoff *et al*. (2013) argue that limited access to mental health services in rural communities can also result from the lack of *acceptability* of this specific type of resource, even when available. Studies show that rural areas experience a strong stigmatisation of mental illness (Bhavsar and Bhugra, 2020), exacerbated by the fact that, in small communities, anonymity can be compromised when seeking treatment (Jensen *et al*., 2020; Nicholson, 2008). Furthermore, the low visibility of mental health services in these communities can lead to a culture of self-reliance which can prevent people from seeking early support, only doing so when they have reached 'crisis' stage (Jensen *et al*., 2020). To better understand these challenges, social geography studies have explored the dynamics of exclusion experienced by people affected by mental illness in rural areas (Parr *et al*., 2004).

In the UK, the provision of mental health services in rural contexts has been further exacerbated by the economic crisis, Brexit and the austerity measures implemented by state policies (Cummins, 2018). Furthermore, farming and other agriculture-related sectors are known to face particular mental health challenges in the UK, with higher-than-average rates of depression and suicide (King *et al*., 2023). This has been associated with recent "shocks" – such as floods and animal culls[1] – that have occurred in some rural communities in the UK, and the lower rates of health-seeking and isolation that is characteristic of the largely male farming community (King *et al*., 2023; Daghagh Yazd *et al*., 2019).

Increasing attention has also been given to the mental health needs of young people (Costas and Smith, 2020) living in rural areas. Whilst there is an increasing prevalence of mental health issues in young people globally, exacerbated by the COVID-19 pandemic (Singh *et al*., 2020) and funding is increasing in the UK government agenda on mental health for this population group, there are still many challenges in accessing mental health support for young people (Radez *et al*., 2020). There are distinctive challenges for young people living in rural areas, including "*poor transport infrastructure, fewer local choices, alienation and isolation, poor digital connectivity, and a lack of opportunities to socialise with peers outside of school"* (Allwood, 2020, paras 1).

The UK parliament has started to acknowledge these difficulties and developed a Rural mental health plan 2023/2024 with the aim of improving the quality of mental health provision in rural areas. This plan mainly focuses on male farmers and young people but does not take

[1]The world is currently suffering its worst avian influenza outbreak, with millions of poultry culled. Meanwhile, last year more than 22,000 cattle were slaughtered in England due to bovine tuberculosis (bTB). See https://www.bbc.com/news/science-environment-65625993 and https://www.gov.uk/government/statistics/incidence-of-tuberculosis-tb-in-cattle-in-great-britain

into account the needs of the whole rural community. However, UK-based studies suggest that perinatal women in rural areas are at higher risk of depression and anxiety compared to women living in urban areas (Ginja *et al*., 2020). Additionally, in the last ten years, the UK rural population has experienced strong diversification (Neal *et al*., 2021a). With the European incentive[2] aiming to renew rural generations, jobs and farms (Combe and McKee, 2020) and the process of dispersal[3] throughout the UK, rural and agricultural areas, such as the East Midlands, have seen dramatic changes in their population.

In 2021, the UK Government highlighted that all migrants are subject to greater risk of experiencing mental health issues than the general population, particularly those more vulnerable such as people seeking asylum, people who have been trafficked and low paid migrant workers. However, reports suggest migrants are less likely to seek help (Bignall *et al*., 2019). Some of the identified obstacles encountered by migrants and ethnic minorities in need of mental health support in Europe and the UK include the increasingly 'hostile environment' towards immigration, racism, the skills gap, language barriers, different understandings and stigma towards mental health problems; and a lack of access or knowledge of services (Satinsky *et al*., 2019; Pollard and Howard, 2021). Studies exploring what enables access are, by contrast, limited (Filler *et al*., 2019) stressing the importance of cultural training for staff, and the creation of multidisciplinary collaborations between mental health and nonmedical services (Giacco *et al*., 2014). This has added new challenges to the rural mental health services, which are not prepared for the diverse needs of various groups of migrants (Neal *et al*., 2021).

This paper therefore considers the complexity of reaching multidimensional rural populations and communities. However, rather than focusing on the lack of mental health services in rural areas, we provide a different perspective that aims to maximise what already exists in communities. We do so, looking at a 'community mental health model' applied in rural communities in Ghana to identify potential key lessons. Following the WHO definition of health, we define community interventions as "those that involve multi-sector partnerships, emphasise community members as integral to the intervention, and/or deliver services in community settings" (Castillo *et al*., 2019, p. 35). There are various types of community mental health interventions employed across the UK, but their implementation is

[2] While the incentives approved in 2021 are aimed to support the young generation of farmers and greener farming, these have also allowed important changes in its population. See website https://agriculture.ec.europa.eu/common-agricultural-policy/income-support/young-farmers_en#:~:text=EU%20countries%20must%20dedicate%20an%20amount%20corresponding%20to,investment%20support%20would%20be%20counted%20towards%20this%20target%29

[3] Under section 95 of the UK Immigration and Asylum Act 1999, once a person is officially recognised as an 'asylum seeker', they are subject to 'dispersal'. During this process, they are relocated in areas all over the UK. This process was ratified with the aim to avoid the concentration of people seeking asylum mainly in certain urban areas (e.g., London) and equally distribute costs across all local authorities (Bloch and Schuster, 2005).

quite fragmented and limited (Duncan *et al*., 2021). Moreover, they focus on individual risk factors (e.g., loneliness, stigma) and protective factors (e.g., community safety) (Duncan *et al*., 2021), rather than empowering the whole community to support people affected by mental illnesses.

Although we acknowledge the multiple differences between the UK and Ghanaian contexts in terms of rurality, family practices and service provision, we argue that this model has potential for enhancing the *availability* and *acceptability* of mental health services in underserved communities. This model can provide a more sustainable solution to address the problems of communities in transformation such as the UK rural community.

Mental health services in the Ghanaian context

This section examines, first, the legal and socioeconomic context of the Ghanaian mental health system, and then, describes the community mental health model applied in a rural area of Ghana. Mental health services in Ghana have undergone much transformation since the introduction of formal biomedical services by the British colonial government (Kpobi *et al*., 2014). From focusing on a social protective framework to institutional care models introduced post-independence, formal mental health care in Ghana has often lagged behind in terms of structural and political interest or support (Osei *et al*., 2021). The long-standing emphasis on institutional care meant that a greater part of the country was largely unserved for several years given that only three specialist psychiatric hospitals existed in the country – all of which are located along the southern coast. There were also no community-based services in rural parts of the country (Roberts *et al*., 2014).

However, in 2012, a new Mental Health Act (Act 846) was passed after decades of advocacy (Osei *et al*., 2021). This new Act takes a rights-based approach to mental health care and places greater emphasis on community-based interventions (A2 *et al*., in press). The law provides for the expansion of community services and integration of mental health into primary care. Since the passing of Act 846, small mental health units have opened in several districts, run by community mental health workers. This has resulted in increased access to mental health interventions for people in rural and remote communities (Weobong *et al*., 2023).

In establishing community mental health services in rural areas, they adopt indigenous concepts of ‘community’. While community-based care in the UK has historically been about providing biomedical and social care within community settings (Handerer *et al*., 2021), including providing individual support and assisted living models, community care in the Ghanaian context has focused on supporting families and caregivers to strengthen care within existing social and cultural frameworks. In the Ghanaian context (as elsewhere), family is not limited to immediate kin (Kuyini *et al*., 2009). Families could include several

generations of kinsmen with a recognised head who may not necessarily have a 'direct' blood link with the individual. Therefore, in addition to introducing psychiatric units within community health centres, community workers also work with families and community leaders to support people with mental health problems. In personal communication with community mental health nurse, Stephen Asante, with whom one of the authors has had long-standing collaborations, he explained:

> "...*I travel to a lot of [remote] areas to look for people who, because of their mental illness, are marginalised, they are being treated badly and see how we can engage the family to support them to get better care… The main institution that we deal with is the family…So we engage the family and we […] explain their condition to their family members for them to understand and also give us their support…we make sure that we get responsible, reliable family members who can support them.*"

The work of nurses such as Stephen is therefore structured around what the family and community accept as constituting care. This is an important approach to interventions because the collectivistic way of life in such communities means that health decisions do not rest with the individual only. Rather, families are a key determinant in health-seeking decisions and choosing pathways of care (Read and Nyame, 2019). A major contributor to this familial system is the agrarian lifestyles of rural and remote communities in Ghana, requiring active involvement of all family members in everyday activities, and this can extend to the forms of health interventions considered acceptable.

Although psychiatric services are now more available in rural Ghanaian communities (Weobong *et al*., 2023), there are existing illness beliefs and health-system limitations which contribute to the use of alternative health practitioners like traditional and faith-based healers (Lambert *et al*., 2020) who work through spiritual and social mechanisms to treat illness and provide support for families in distress. Often, the decision to seek help from traditional healers is similarly taken by the family. In some cases, the healers provide residential facilities where supplicants live for periods of time while they undergo healing (Gyimah *et al.*, 2023). In these healing centres, residents form micro-communities of care as an extension of the larger community. These communities of care provide emotional and (sometimes) financial or logistic support to each other, recreating the family systems present in the larger community context. In this way, the community interventions are owned and driven by the members of the community.

Recognising the presence of (and sometimes, the preference for) non-biomedical health practitioners and the value of these communities of care, Act 846 further seeks to actively harness existing community resources by forming partnerships with healers (Read, 2019). These partnerships involve active collaborations between health workers, traditional healers

and family members; working together to provide integrated care which includes biomedical interventions, spiritual care and social care for people in rural communities (A2, *et al*., in press)[4].

To illustrate the community care approach that is utilised in Ghanaian rural communities, community mental health workers actively seek people with mental health problems by engaging with families and healers in the community. They search for people receiving treatment from healing centres and those who have received institutional care in the past and have returned to the community (A2 *et al*., in press). They provide psychiatric interventions but also identify ways to empower and support families by facilitating social welfare support and partnering with community organisations. Nurse Stephen has been involved in such initiatives through his foundation, the Mental Health Advocacy Foundation:

> "...*aside from the medication [...] we empower them economically… Because a lot of the people here are farmers. So, what we do is that we provide them with resources like seed, fertiliser, [we help to] clear their land and prepare their land for them so that they can cultivate something. And at the end of the day when they sell the produce from their farm, they can be able to use it to support the sick*…"

Initiatives like the ones described above enable community interventions to be incorporated into the existing way of life of the rural communities. Consequently, it improves not only the availability of the interventions, but also enhances their acceptability within the communities by including the important function of the family in the approach to care.

Key lessons: applying the Ghanaian model in the UK.

In the preceding section, we described the rural Ghanaian experience of a 'community mental health intervention'. The mental health nurses work in partnership with family, schools, neighbourhoods and healing centres to support people affected by mental disorders. Essentially, the 'whole village' becomes an integral part of the intervention. In this way, this model works transversely across the two dimensions of *availability* and *acceptability.* With respect to *availability*, the Ghanaian model provides mental health care to people affected by mental illness through the empowerment and engagement of the whole community. In a context with very limited resources, it allows the optimisation of existing resources (e.g., family, neighbourhood, religious and educational institutions). In terms of *acceptability* of the services, the involvement of the community facilitates the development of

[4] An ethnographic documentary which shows how these collaborative partnerships work was part of the *Together for Mental Health* project. Further details available at https://movie-ment.org/together4mh/

trust and the reduction of stigma (Monnapula-Mazabane and Petersen, 2022; Alemu *et al*., 2023).

Several important lessons can be learned from the Ghanaian model. A first important lesson for the UK context is the importance of identifying community assets that are specific to the local population. Identifying assets and resources available in the rural community has already been acknowledged as an important strategy to health inequities (Mughal *et al*., 2022). However, this is of crucial importance in the prevention, support and recovery of mental disorders (Jorm, 2012). In the Ghanaian model, mental health nurses work in strict collaboration with the local villages. They cultivate familiarity in the community by partnering with community leaders and other stakeholders. They form connections with traditional healing centres and identify important family structures to create networks of support. These networks allow them to identify people affected by mental disorders, form connections with families, and consequently, facilitate recovery.

Empowering communities to support people affected by mental illness was one of the key values of deinstitutionalization because it reduces admission in psychiatric hospitals (Mezzina, 2020). While these collaborations address the issue of the *scarcity of resources*, they are also important for the *acceptability* of the treatment. According to Jensen et al. (2020), rural communities are characterised by the formation of a very specific community culture. Identifying existing social and community places that are acknowledged and trusted by the population as *sites of support* could be a positive strategy to increase reach and build trust. This is a crucial consideration for the evolving landscape of British rural communities and particularly important in migrant and other marginalised or vulnerable communities (Bäärnhielm and Schouler-Ocak, 2022). In the Ghanaian example, the partnership has been developed with healing centres as trusted and validated places for seeking help and support. Similarly, each rural area possesses specific sites of support where people turn to meet their needs (e.g., community centres, parishes, local pubs and religious premises). Thus, this approach has the potential of reaching underserved and more difficult to reach communities using spaces that are already recognised as ‘safe’ for seeking help.

A second key learning, which is intertwined with the previous point, is the importance of exploring partnerships and collaborations with non-medical people (e.g., religious figures, non-medical practitioners, educators, teachers). By working with lay community members who are respected, the difficulties with accessing mental health services due to stigma can be minimised (Bischoff *et al*., 2013). Furthermore, by training such stakeholders to also help with case identification and referral, it broadens the reach of services (see for example, the Friendship Bench project). By identifying common cultural, religious and/or communal beliefs, interventions can be developed which allow people to engage with members with whom they feel comfortable. This is especially important in the UK where communities are

evolving and becoming increasingly diverse with a multiplication and coexistence of beliefs, cultures and needs.

A third lesson is associated with the concepts of integrated care and continuum of care. Integrated care has been proposed in the UK as a more efficient person-centred model for people affected by illness (Tracy *et al*., 2019). Through engagement with the local community, the Ghanaian model allows the creation of a network of collaborations around the person affected by mental disorders living in the community. While this has developed due to limited access to other professionals, such as social workers and crisis teams, it has allowed the mobilisation of existing community resources and the promotion of self-management to prevent crises and hospitalisation.

Conclusions

This paper illustrated a model of mental health care applied in a rural area of Ghana. We argue that there are important lessons that can be learned from this model by communities in the Global North, such as the UK, to reach the rapidly transforming rural communities with the aim to improve access to mental health services. First, the importance of identifying *community assets* that are specific to the local population which acknowledge the meanings of 'community' to the populace. Second, the importance of exploring *partnerships and collaborations with non-medical people*; and finally, the *mobilisation of existing community resources* and the *promotion of self-management* to prevent crises and hospitalisation.

These reflections are an invitation to explore the differences, similarities and potential learning from the community mental health models applied by the two countries to reach rural communities. For instance, the Ghanaian model described in this paper bears some similarity with the Social Prescribing Link Worker Model[5] recently implemented in England, especially in terms of the role played by social prescribers to reduce loneliness in people affected by mental illness and to connect people to community-based support. One of the main challenges for social prescribers using this Model is maintaining the link with the person affected by mental illness when the person is 'in crisis', and the development of a trusting relationship can be affected. This consequently impacts the effectiveness of the service (British Red Cross, 2019). In the Ghanaian system, it is the community mental health nurse who works as a 'social prescriber' and as such, they are also the person who intervenes in the moment when the person is 'in crisis'. Additionally, the community mental health nurse works with the family and, in some cases, community leaders, not just with the

[5] For more information on this scheme, please see the NHS page.

individual. It is therefore worth examining the potential of redefining the social prescribing model to incorporate wider connections between families, communities and health systems.

This links to another important consideration for further study: the importance of recognising cultural differences in the role played by the family in the treatment of mental illness and how this impacts on psychiatric practices and services. In the last decade, the World Health Organisation's Mental Health Action Plan (2013–2020) and the Royal College of Psychiatrists (RCPsych) have called for greater collaboration with families in the delivery of mental health services and in the drive for deinstitutionalisation. While there are important positive impacts of family interventions (Yesufu-Udechuku et al., 2015), recovery approaches in the UK, including the social prescribing model, are still predominantly individualistic (Pryce-Robertson et al., 2016). The acknowledgement of locally derived definitions of 'family' and 'community' in the Ghanaian example, highlight the potential for looking at family involvement in a less individualistic manner. Given the increasing diversity of rural communities in the UK and the diversity of what 'family' means, incorporating contextual perspectives of family support can be an important impact, and bears further examination.

In these ways, this paper is an invitation to look at community mental health models implemented in other areas of the world, especially the global south, to explore their utility in a rapidly evolving and transforming northern landscape. By examining the approaches that have been implemented in contexts with limited resources, important lessons can be learned, which may find utility in countries like the UK.

Despite the important lessons identified, we acknowledge the limitations of this reflective paper, principally the fact that this discussion is not based on empirical research, but rather an initial reflection of the potential utility of a model of care from the global south. In terms of challenges applying this model in the British context, the first important issue is linked to the differences in family models that are reflected also in the type of policies enacted. Mental health services in the UK aim to enhance the independence and autonomy of the person affected by mental illness. While the 'nearest relative' is a figure acknowledged in the Mental Health Act 1983, there is controversy around the problem of privacy and giving patient's information on the basis of 'blood' connections. In Ghana, by contrast, the main point of support is the family.

A second important point to consider is the difference in the geographical meaning of 'rural' between the UK and countries like Ghana. While Ghana has an identifiable rural-urban divide, a significant number of communities typically classified as 'rural' are also remote communities which are underdeveloped and often hard to reach. This is not the case for most rural communities in the UK. While this difference in classification does not necessarily

constitute a barrier, it is important to acknowledge as it may simplify the identification of community assets.

The enormous responsibility left in the hands of the community mental health workers is the most evident weakness we identified in the sustainability of the Ghanaian model. The absence of logistic and (often) financial support means that the success of community-based mental health interventions rests on the resilience, dedication, and resource-mobilisation skills of the community health nurse. In the UK, by contrast, where the health and social care systems are better structured, it would be possible to create a multidisciplinary team working together to identify important community assets. Moreover, community engagement allows care to be driven by the community, so the interventions can also evolve as the communities evolve, thereby making them more sustainable.

Despite these limitations, this paper serves as an initial basis of reflection for more in-depth work to explore the potential of learning from the Ghanaian model to improve rural mental health in the British context.

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