Between chains and vagrancy: the limits of family care for the mentally ill in rural Ghana

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Introduction

In the 1940s Geoffrey Tooth, a British psychiatrist, was commissioned to undertake a study of mental illness in the then Gold Coast. In his report he concluded that in the North of Ghana "There appears to be little social stigma attached to madness, lunatics are well treated in their homes and even when shackled to a log in the traditional manner, the madman is seldom alone for long, is well fed and enjoys the company of his children and friends' (Tooth 1950:30). He contrasted this with the mentally ill he met in the south of the country where he concluded that mental illness was a disgrace, leading to the confinement of the person, or their expulsion from the family home. This contrast between rural and urban responses to mental illness in Ghana has been made more recently in a study of carers of people with mental illness. The author argues that in rural areas there is greater social acceptance of people with mental illness due to more community support and closer kinship ties (Quinn 2007). Such claims regarding the tolerance and support of the extended family for the mentally ill in Africa have been common in the literature of cross-cultural psychiatry. Sow argued that: 'Chronicity is generally less pronounced in Africa than it is in the West. This difference seems to be due mainly to great tolerance on the part of the community, which facilitates rapid reintegration into the family group, as well as to the quality of human relationships' (1990 [1978]:30).

However such statements are seldom backed with in-depth exploration of family responses to a mentally ill relative, particularly over time, and are vulnerable to an idealised contrast between alienated industrialised societies and close-knit ‘traditional’ rural communities.

My own research among families in the Brong Ahafo region of Ghana, suggests a more varied response to mental illness among rural families than this polarised contrast between urban and rural would suggest. In this paper I suggest that family responses to mental illness may be situated along a continuum between rejection and coping, whose furthest limits range from vagrancy at one pole, to chaining within the home at the other. Families may also move from restraint to rejection or resignation within the lifetime of an illness, thus the ‘snapshot’ perspective of much research may fail to reflect variations in family response over time, capturing rather an either/or response of rejection or acceptance. Furthermore, chaining may not represent a position of rejection, but a form of ‘care’ when family choices and social support structures are pushed to the limits. In the face of severe mental illness and behavioural disturbance, there are few options outside the family which provide alternatives for humane care, despite the apparently diverse array of treatments, since neither the formal structures of Ghana’s health service, nor the informal sector of traditional and faith healers, are equipped with the means to provide care and treatment according to the ideals of international human rights and health care organisations.

The attempts to manage the mental illness of a family member are also to a large extent determined by social norms regarding the control of mental illness which are informed by historical, cultural and symbolic practices and forms of relation. Such social norms become the accepted, or even expected, practices in response to mental illness, and hence do not evoke widespread protest, particularly at the community level. Yet the international discourse of human rights often fails to address the symbolic and cultural categories which may inform and reinforce the practices employed by families in coping with a mentally ill relative. Since these practices may work at the level of ‘habitus’, as an unconscious reproduction of culturally familiar responses to madness, an awareness of their historical and cultural roots may help to explain why such practices endure and may be most resistant to change.

The study

1 Bourdieu defines habitus as ‘systems of durable, transposable dispositions…principles which organise and generate practices and representations’. The habitus represents the embodied, commonsense way of being and acting in the world. Its reproduction is unconscious, it is ‘embodied history, internalized as second nature, and so forgotten as history’ (Bourdieu 1990:53-56).
This research explores the responses to mental illness within a rural community through a longitudinal anthropologically informed study of people with mental illness and their families which views family responses as embedded within such cultural and historical contexts which provide the 'stock of knowledge' (Schutz 1970) on which people draw when confronted by the demands of such experiences. By considering the perspectives of those with mental illness as well as their family members, it explores the impact of mental illness on the individual and the family, and the steps taken to manage the challenges presented by the person's behaviour and the breakdown of social interaction along expected norms. These include not only the responses of the family, in terms of help-seeking and methods of restraint, but the responses of the mentally ill person when social interaction and daily routine becomes difficult.

The study is being conducted in Brong Ahafo, a rural area situated in the central belt of Ghana, at the boundary between the forest and savannah zones. The study centres around a rural town, Kintampo, which forms a transit zone between north and south, and is home to many migrant communities which have now settled in the town. The most widely spoken language in the district is Twi, which is spoken by the Akan, who represent the largest ethnic group in the region as well as in Ghana as a whole. However Twi is also adopted by most living in the area as a lingua franca, although many people speak at least one other language, in particular Hausa which forms the lingua franca among Northern migrant groups. Many of these northern groups migrated to the town during the slave trade, and Kintampo was an important trading centre for slaves following the decline of the slave market in Salaga (Arhin 1979). Kintampo also marks the boundary between two administrative districts, North and South Kintampo. These two districts are the location of many rural communities, some of which are strung along the main north-south road, others located at some distance along unpaved feeder roads. Farming is the major occupation for about eighty per cent of the population in the districts.

There are three major sources of help for families in Kintampo North and South districts who have a relative with mental illness, including biomedical healthcare, ‘traditional healing’, and ‘faith healing’ from Christian pastors. Ghana Health Service is the main provider of biomedical care for mental illness, however treatment for mental disorders seldom penetrates to the community level. Until recently there were no mental health professionals throughout the two Kintampo districts. A Community Psychiatric Nurse (CPN) now been posted to Kintampo. In theory she provides a service to the town and surrounding communities, but since she is provided with no means of transport she is limited in her capacity to conduct home visits on a regular basis, particularly to more distant communities. Treatment for mental illness at the community level is largely through the provision of psychotrope drugs which are available from the district hospital at Kintampo and from the CPN. However there are sometimes problems with the supply of psychotrope medication and the range of drugs is limited. Clinics located in rural communities within the districts do not supply psychotrope drugs, and are staffed by personnel with limited training. Specialised psychiatric care is available beyond the boundaries of the district in Techiman where there are 2 CPNs, and in Sunyani, the regional capital, where there is a psychiatric unit within the regional hospital. The three state psychiatric hospitals which provide the major source of inpatient care are all located in the south of Ghana, a day’s journey from Kintampo.

Many communities have an ôkômfo, a traditional healer or fetish priest, who under the instruction of the abosom or ‘small gods’, will provide herbal and ritual treatment. Also popular as sources of healing for mental illness are ‘prayer camps’, churches which provide healing through prayer, fasting and deliverance from evil spirits. There are two pastors in Kintampo town who are well-known for their power in healing abodamfo, those who are mad. A shrine in a small rural community in Kintampo South district is also famed for healing madness and is visited by people from as far afield as the Ashanti region and sometimes beyond. Treatment in prayer camps and shrines often involves a lengthy stay of several months; frequently up to a year or even more.

This research draws on observation, conversation and semi-structured interviews with over 30 families with a relative with mental illness within Kintampo town, and within rural communities within the two Kintampo

2 Man in daily life......finds at any given moment a stock of knowledge at hand that serves him as a scheme of interpretation of his past and present experiences, and also determines his anticipations of things to come (Schutz 1970:74)

3 The Akan include a number of subgroups including the Bono from Kintampo and Brong Ahafo, elsewhere the Ashanti, Akuapim and Fante.

4 All words in italics are in Twi.
districts. The research was conducted by the author together with an assistant who provided interpretation and conducted interviews in Twi. The study is anthropological, grounding the study of mental illness within the social and cultural world of the informants, and taking an approach which is informed by the cultural meanings of madness, rather than by biomedical categories. The persons defined as mentally ill are those who in Twi would be described as *ôbôdamfo*, or a mad person. This behaviour is clearly identified by local informants with forms of ‘wild’ and anti-social behaviour and is closest to what in psychiatric terms would be labelled psychosis. Frequently described behaviours include talking to oneself, talking in a disordered way (*kasa basabasa*), acting aggressively and dressing in dirty clothing.

The study focuses on those with more longstanding forms of mental illness which involve severe disruption of perception, thought, and social functioning. The majority of those studied have been ill for periods of at least 5 years, many for much longer than this. Many traced the onset of their illness to adolescence or early adulthood. Some of the cases were previously identified through a population-based epidemiological study of psychosis conducted in 2002-2003. Some were identified through contacts in the town, others were encountered at the shrine and churches. This later group includes some from outside the Kintampo districts. Whilst the current study commenced in May 2007, previous formative research had been conducted in the same study area in 2006, thus some of the cases have been known to the researcher for 2 years.

**Chaining as family care**

The chaining of people with mental illness, in particular those deemed ‘mad’, is not exclusive to Africa. Within the history of psychiatry the unchaining of the mentally ill was one of the most radical transformations in European treatment of the mentally ill towards the close of the eighteenth century (Shorter 1997). Yet the sight of a madman in chains is perhaps the most overt and, to an outsider, the most shocking evidence of attempts to cope with the behavioural disturbance arising from mental illness in present day Ghana. However this research reveals that the reasons underlying the chaining of people with mental illness are varied and embedded in long-standing cultural practices. The need for methods of restraint in the absence of easily available neuroleptics and custodial care within psychiatric institutions might at first seem the most obvious reason for chaining of the mentally ill. However, the fact that the unchaining of the mentally ill in Europe occurred in the absence of effective pharmaceutical alternatives and in the context of changes in concepts of the person in post-revolutionary France and the Age of Enlightenment (Porter 2002), suggests there are other underlying cultural and historical factors which might reinforce such a response.

**The case of Samuel**

Samuel was one of those who had been identified through the psychosis study. When we found him five years later he was little changed. Now 39 years old, he was living with his family within the compound of the family house in a typical rural community accessed by an unpaved road. Naked except for a piece of rough sacking, he was seated on a bare wooden bed in a room with walls so broken down that they were open to the elements and to the view of any passers by. The room was bare of any other furniture and stank of stale urine and sweat. Around Samuel’s ankles was a close-fitting pair of shackles attached to a heavy metal weight. Samuel had represented the hopes and aspirations of his family. From his humble origins as the son of a farming family, he had completed secondary school and attained admittance to army training school in Accra. This represents a very high level of achievement within such a community. However this success was short-lived as Samuel began to break down, and had to leave the army barracks. His confinement within the family compound represented the end point of a lengthy process of help-seeking extending over 20 years. His family had approached renowned shrines and prayer camps in the region, as well as the community psychiatric nursing services at Techiman, incurring considerable cost in transport and payment for healers. There had been no significant improvement following all these avenues of treatment. Samuel remained ‘mad’, deluded and grandiose. The most troublesome of his behaviours was his harassment of the neighbours since he believed that he owned their house, and would argue with them asking them to leave. In such a small community where people live in close proximity such behaviour could provoke significant difficulties and it was this that had led the father to resort to chaining his son. He could also be destructive. His family had resorted to covering him with sacking since he tore up

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5 All names have been changed

6 I once observed a pastor conducting an activity in which mothers were asked to name their aspirations for their children’s future career. Doctors, lawyers, policemen and soldiers were the most popularly-named choices.
any clothes he was given. Samuel was too unwell to consent to a formal interview, yet his comments to us revealed his perception of his status: ‘I am a prisoner’, ‘They are treating me like a monkey’. Indeed he was living in worse conditions, and with less freedom, than the goats which roamed around the compound, and was prey to the mockery of passing children and drunken men.

However Samuel was also cared for to some extent despite his appearance. His family prepared his meals, brought him water to bathe, trimmed his hair, and provided everyday social interaction. He was, even in his severely compromised status, still within the community, visible as the son of his father, and a member of his household. Unable to work or bring in any income, Samuel was solely dependent on the support of his family. Having lost many of his friends, his family were also his major source of social contact. Samuel himself expressed rejection of his family, talking about himself as a ‘bastard’ who had no father, and claimed that he was related to Jerry Rawlings, the former president of Ghana, and a popular figure for many in the district, an NDC stronghold7. Whilst his speech was disturbed and his comments could be seen as merely grandiose, part of his psychotic symptoms, they also reflect the breakdown in the expected interaction between father and son, in which as he said, his father had become his jailor.

Our visit to Samuel led to a referral to the CPN, who prescribed medication which the family undertook to supervise. However improvement was limited as might be expected in such a long-standing condition. Nonetheless the father felt Samuel had become sufficiently calm in his behaviour for him to remove the heavy weight which prevented him from moving around. However he remained nervous about removing the shackles for fear of Samuel returning to harass the neighbours.

**Chaining as family care and cultural practice**

Madness, because it can lead to extremes of behaviour which can be violent, pushes families to limits where the choice of action is to some extent predetermined both by the paucity of state support, and by the categories within which madness is situated. In Samuel’s case, as for others we encountered, there are few alternatives for the family in coping with their disturbed son. One option would be to take Samuel to the psychiatric hospital, however he would then have been far removed from the family, and it was very likely that once he returned home he would not have continued to receive medication, thus likely to relapse. He could have remained in a shrine or a church, where he would also have been chained, and vulnerable to beatings, enforced fasting or other maltreatment. Or he could, at the other extreme, have been allowed to become vagrant, and ultimately lost to his family. Thus the chains represented a desperate measure to maintain the son within his family home, and therefore a form of family care and involvement, in contrast to other alternatives of abandonment or rejection. Poverty too, influences family responses, since the standard of buildings within which Samuel’s family lived, and which are typical of many rural farming communities, was constructed from broken-down and eroded mud bricks, with thatched roofs. Such buildings are inadequate to provide secure accommodation in which Samuel could have been detained in any safety or privacy.

The response of Samuel’s father to his son’s condition also lies within the range of expected responses to madness within rural Ghanaian society. Almost all those with mental illness encountered in this research had been chained, either at home, or within healing centres. A Twi proverb *Baakofo nkye bōdamfo* (one person cannot catch a madman) mirrors the strong association of madness with aggressive behaviour, and even superhuman strength. Aggression may force the family to consider forms of restraint such as chaining in order to protect themselves, and is one of the behaviours which leads to the family bringing their relative to places of treatment such as shrines, churches or hospitals. However shackling is not always a response to violent or uncontrolled behaviour. Sometimes it appears as a form of punishment, since madness has connotations of immorality associated with a belief that madness represents punishment for transgressions such as breaking of taboos, stealing and adultery. Madness is also associated with smoking cannabis, which is strongly morally sanctioned, representing a form of marginalised and anti-social behaviour particularly among young men.

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7 Jerry Rawlings is the former leader of the National Democratic Congress (NDC), and a controversial but still popular figure, particularly in the North of Ghana and the Volta region where for many he has achieved heroic status. The NDC is one of the three major political parties in Ghana, currently in opposition to the ruling New Patriotic Party (NPP). The two Kintampo districts are represented by MPs from the NDC.
Shackles also play an important part in the treatment of those with mental illness in informal healing centres in Ghana. In both prayer camps and shrines it is common for the person to be chained when they are admitted, though the chains are removed once the person becomes calmer, sometimes after a few days, or a couple of weeks. In very agitated cases, or where the person is thought to be likely to run away, the chains may be kept on for months. Shackles allow healers to enforce their treatment by preventing the person from leaving the shrine or prayer camp, or running away to break a prescribed period of fasting. Every healer I encountered, whether a Christian pastor or a traditional healer, uses shackles to restrain those with madness. None had any form of accommodation of a standard suitable to detain aggressive or destructive patients. Chaining of patients is also conducted with the full co-operation of the families who bring their relatives to healing centres. Indeed, it is often the family members who purchase the shackles used to restrain their relative.

Since they are used exclusively for the chaining of a mad person, yet draw on historical practices and categories, the shackles represent a symbolic cultural object par excellence, identifying madness in the way that the wearing of beads at the waist denote femininity. They are stigmata, marks of madness. The form of restraint employed in family homes and in shrines and churches in this part of Ghana is always a similar design. A pair of shackles are attached to the ankles preventing the person from walking except at a hobble, and sometimes attached to a tree or a post. Shackles are locally made by welders who are familiar with the design and its purpose. They consist of metal bar with two u-shaped pieces to enclose the ankles and are closed with a padlock. These shackles are similar in design to those used on slaves which can be seen on display in the slave castles on the coast (see figs 1 and 2). Madmen, like slaves, may be seen to have descended to a status outside human sociality: as one informant told me, mad people do not follow social rules and regulations. Within Ghana responsibility for others, such as parenting children, is valued as the mark of adulthood. If they are unable to bear responsibility for themselves or others, those who are mentally ill may be viewed as somehow less than fully human. The Ghanaian philosopher, Kwasi Wiredu encapsulates this view of the person. He writes that for the Akan ‘a person in the true sense is not just any human being, but one who has attained the status of a responsible member of society’, that is someone who ‘is able to achieve a reasonable livelihood for himself and family while making non-trivial contributions to the well-being of appropriate members of his extended kinship circles and the wider community’ (1996:129). All of those we met suffering from chronic mental illness were falling well outside this ideal of personhood since, like Samuel, they were unable to work, and all were unmarried and childless.

Fig 1: Shackles used for slaves displayed at Elmina castle
The removal of the shackles also serves a symbolic purpose for those who treat mental illness since it is a tangible and dramatic demonstration of the efficacy of healing in effecting the transformation of the person from madness to health; from asociality to humanity. Thus one of the healing pastors is able to proudly display his collection of photographs of madmen in chains as evidence of the efficacy of his healing, rather than a shameful record of abuse, since it is he who is responsible for both the shackling and removal of the chains; imprisonment and liberation. For relatives too, the release of their son or daughter from chains, offers visible evidence of improvement. Some of those interviewed who had been chained at the church expressed little resentment towards the pastor who had chained them, recognising it as a necessary part of their healing. Some chose to stay and serve the pastor, training as pastors themselves and doing other work such as farming, maintenance and running errands. Indeed, the church may come to form a substitute family, especially where, as in some cases, the family have abandoned their relative to the care of the pastor.

Human rights and family cohesion

Thus the use of shackles on those with madness provokes little social protest at the community level. Whilst national newspapers occasionally print pieces which criticise the practice (Asiedu and Kwei 2004), within Kintampo there has been no move by police, social welfare or the local office of the Commission for Human Rights and Administrative Justice (CHARJ) to sanction the practice of chaining, either by individual families or by healers. Furthermore, legislation to protect the rights of the mentally ill in Ghana is weak and there is no state supervision of healing facilities such as prayer camps and shrines. The Mental Health Decree (1972), which forms current mental health legislation, does not address the issue of restraint or maltreatment by relatives or healers, although it does provide for the police to remove to ‘a place of safety’ any person suspected of suffering from mental illness who ‘has been, or is being, ill-treated, neglected or kept otherwise than under proper control’ (National Redemption Council Ghana 1972).

The Constitution of Ghana which aims to protect the rights of all citizens of Ghana, also makes allowance for the detention of ‘a person of unsound mind, a person addicted to drugs or alcohol or a vagrant, for the purpose of his care or treatment or the protection of the community’ (Government of Ghana 1992 Clause 14(1)). Yet whilst the Constitution thus sanctions the detention of people with mental illness under certain conditions, it also states that no person who is restricted or detained should be subjected to ‘cruel, inhuman or degrading treatment or punishment’ and ‘any other condition that detracts or is likely to detract from his dignity and worth as a human being.’ (Ghana 1992 Clause 15(2)).

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8 The lack of concern with human rights in this legislation is not surprising since the law was passed under the military government of Colonel Acheampong.
This provokes the question as to whether chaining of those with mental illness is perceived by those who employ it as degrading, inhuman or cruel, or whether it is rather viewed as an unfortunate necessity, or even as mundane. There are limited alternatives within Kintampo districts to manage those people with mental illness who do become aggressive, or who attempt to run away from the family home, particularly within more remote rural areas. Pastors and traditional healers in the area claim they are providing a vital service for the management of those with mental disorders since they view their treatments as effective, and see little evidence of better alternatives within biomedical treatment. For families confronted with an agitated or violent relative, the churches and shrines are the most obvious and accessible resources to assist in restraint and management, compared to the long and expensive journey to the psychiatric hospitals on the coast. With no ambulance service or medical staff available to provide an escort, families face a challenging task escorting disturbed and agitated family members to places of treatment, particularly if using public transport which is often the only affordable means. They often call on male relatives to provide manual restraint, or as in one case encountered, come to a private arrangement with members of the police force to handcuff the person and restrain him or her during the journey.

Some have viewed the legal promotion of the human rights of those with mental illness as a solution to practices such as chaining. A new mental health law has been drafted in Ghana which overtly adopts a ‘human rights based approach’ reflecting current international guidelines as articulated by the World Health Organization (WHO 2005), although it has not yet been passed9. This bill explicitly prohibits abuse within healing facilities, including traditional healers and ‘spiritual mental health facilities’, and repeats the right of police as stated in the Mental Health Decree to obtain a warrant to remove a person from private premises to a place of safety (Government of Ghana 2006). The bill allows for a person to be placed in ‘involuntary seclusion or minimal mechanical restraint only when there is imminent danger to the patient or others and tranquillisation is not appropriate or not readily available.’ (Mental Health Bill 45(1)). However under the terms of this clause the proposed legislation will do little to prevent or reduce the use of mechanical restraint within treatment facilities unless suitable resources are provided at the community level to ensure that tranquillisation is more widely available, and there are staff trained to administer it in safety. Since at the time of research there were no injectable drugs in Kintampo to provide rapid tranquilisation, this clause provides legal sanction for the use of mechanical restraint in the face of the failure to ensure an adequate supply of medication within local health services for those in acute mental distress.

A further caution concerns the congruence of the international conception of human rights with the values of those living in the communities of rural Ghana. Human rights necessarily entail a notion of who constitutes a human being. Yet in the case of mental illness there is a need to consider how to promote human rights for those who are considered ‘outcasts’ within African societies, who are ‘beyond the pale of personhood, because they threaten group solidarity, continuity, or values’ (Messer 1993:228). Those who are mentally ill could be viewed as such ‘outcasts’ from the status of human beings since they have ‘failed to meet minimum standards of behaviour, as these define group members and personhood’ (ibid). The World Health Organization play a leading role in influencing the standards for mental health care in Ghana and worldwide. Yet the notion of human rights as propounded within such international organisations is largely founded on European concepts of the person as self-determining and stresses the autonomy of the individual over the rights of the group. By contrast, the actions of family members and healers reflect a concern to promote the safety and cohesion of the group, rather than the individual rights of the person with mental illness. This properly reflects Ghanaian ideals concerning the sociality of human beings and relationships of reciprocity and responsibility, and the sanctioning of overt individualism (Gyekye 1987, Wiredu 1996). Within Ghana, as Englund describes for Malawi (Englund 2000), human rights may be viewed as grounded within a moral rather than legal framework, one which draws on ‘traditional’ morality as articulated at the shrines, and increasingly on Christian moral codes10. Gyekye writes that 'Within the

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9 There is currently intensive lobbying by professionals within the field of mental health in Ghana to pass this legislation before the Presidential elections in December 2008. This has resulted in some coverage of the issue of the human rights of those with mental illness within the national press and on radio.

10 The African Charter on Human and Peoples’ Rights which was drawn up in 1981 by the Organization of African Unity and came into force in 1986, explicitly stresses an African perspective on human rights, and enshrines the rights of the family, as well as of the individual (African Commission on Human and Peoples’ Rights 1981). The charter states that ‘The rights and freedoms of each individual shall be exercised with due regard to the rights of others, collective security, morality and common interest.’ (Article 27:2). However, whilst WHO points out the commitment of the African charter to the right to ‘the best attainable physical
framework of Akan social and humanistic ethics, what is morally good is that which promotes social welfare, solidarity, and harmony in human relationships'. By contrast, moral evil (bone) is 'that which is considered detrimental to the well-being of humanity and society' (Gyekye 1987:132-133). In this view rights are earned, rather than innate.

However, this moral perspective on human rights may work to the disadvantage of those with mental illness since mental illness may be seen to arise from moral failings. Thus those who are mentally ill may be viewed as excluded from entitlement to the rights otherwise accorded to morally upright and socialised human beings. Their rights are likely to be subsumed to the need for the cohesion of the group, as in Samuel's case, thus sanctioning the use of whatever means necessary to control behaviour which threatens this cohesion. To fail to address the issue of the chaining of the mentally ill, and other practices of restraint, is to ignore the significant cost for those chained: socially, physically and psychologically. Samuel has wasting of the muscles of his legs as a result of prolonged periods of inactivity. Many people with mental illness bear scars on their ankles, evidence of the abrasion caused by the shackles. Chains are also often used at the shrines to both punish as well as restrain those who attempt to run away. Informants described how people with mental illness were beaten with strips of rubber in order to force them to take herbal medication or as punishment for running away. Some, like Samuel, are resentful of the treatment received at the hands of their families, or of healers or pastors into whose care they had been entrusted by family members. In some cases this can lead to a breakdown in family relationships from which some families never recover. The ultimate risk surrounding attempts at chaining and restraining those who are agitated or aggressive, is severe injury or death. In May 2008 a young police officer experienced a mental breakdown whilst in a church in Kintampo, and began to behave aggressively, smashing objects and shouting. As yet the facts of the case have not been verified, however it appears that in the course of attempts to restrain him by church elders, the man's neck was broken and he died. However although the person died within the grounds of a church where chaining is openly practiced, there has been no attempt to sanction the pastor, or to stop the practice of such forms of restraint.

There are some signs of an uneasiness with the practice of chaining, and a desire for other alternatives on the part of those involved in treating the mentally ill. A pastor who recently returned from Bible school in Accra and whose church routinely chains the mentally ill to trees, expressed the opinion that such treatment is 'not the best', and stated his desire for funding so that better facilities for the confinement of patients could be provided. However the voices of those who might most call for change are largely muted. Like Samuel, their opinions may not be heard since they may be clouded by the disordered speech of madness and hence not understood. Even when heard, the words of those with mental illness may be discounted as the merely the delusions of the mad. Yet removing the necessity for chaining and other forms of restraint will not only protect the rights, dignity and health of those with mental illness, it could also help to maintain family relations. As in the case of Samuel, the use of chains may alienate the person from their family, and indeed serve only to worsen their condition. Providing greater support for families to deal with the serious challenges arising from living with and caring for those with very disturbed behaviour can work for the benefit of both the person with mental illness and their family members, as well as the community as a whole.

Conclusion

This paper draws on an ethnographic study of families caring for a relative with severe and chronic mental illness to argue that chaining may represent an attempt to maintain a relative with mental illness within the family home, despite the impact on the family, associated stigma and social cost. It thus could be argued to constitute an aspect of family care in the absence of few avenues of support. Such practices are also rooted within accepted responses to mental illness within the study area, drawing on historical, cultural and symbolic meanings, and thus do not evoke the level of protest that might be expected within a discourse of human rights. Indeed human rights approaches employed by international agencies may fail to engage with
the local meanings underlying practices of restraint, and the primacy of the maintenance of social relations above individual autonomy in this context.

Mental health care predicated on western models is unlikely to be realistic in the context of the limited resources available in Ghana, nor may it be the best response to the particular needs of Ghanaian families within rural communities. Given the important role of families in Ghana in providing care and managing the challenging behaviours sometimes displayed by those with serious mental illness, mental health services need to consider how best they can support the person with mental illness within the family, and work to strengthen the family resources. Mental health care needs to be available at the community level where it will be most accessible to families with few material or financial resources to access treatment at more distant health care facilities, and where road and transport infrastructure presents challenges even for those with means to undertake the journey.

There is also a need to confront deep rooted historical and cultural practices which form the ‘natural attitude’ (Schutz 1970) in responses to mental illness at the level of families and the broader society. This is evidently more difficult, since it involves the changing of attitudes. Institutional change is only one step, although a vital one. Legislation alone is unlikely to alter practices used for the restraint of those with mental illness, unless it is coupled with a commitment to funding mental health services which reach those at the community level, and provide a realistic alternative or adjunct to other treatments. Ultimately it may be the provision of better support for families at the community level which may lead to changes in responses to mental illness, more than the imposition of sanctions which may serve only to drive some practices underground.

References


National Redemption Council Ghana (1972) Mental Health Decree NRCD 30


