**The ethics of psychiatry care and research in resource-poor settings:**

**The case of a psychiatric research trial including chained mentally ill**

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**Abstract:**

A publication in the January 2018 British Journal of Psychiatry (BJP) detailed a clinical trial on persons

with mental illness (PWMI) some who were in chains in a prayer camp setting in Ghana. The camp’s

advertised mission statement was to “set free those held captive by satan....through its ministry of

fasting and prayer”. This article considers the potential ethical problems raised by the clinical trial on

chained PWMI against the background of Ghanaian ethnic-anthropologic beliefs. The article in

highlighting the ethical issues raised by the clinical trial in question attempts to suggest what (and

how) Ghanaian healthcare professionals (HCPs), policymakers and the national government can do

to institute workable, enforceable measures towards ending the practice of chaining PWMI in

Ghana.

**Keywords:** Chained mentally ill patients, Ghana prayer camps, randomized medication trial,

ethical ramifications.

**Introduction:**

An article was published in the British Journal of Psychiatry (BJP) in January 2018 detailing the

conduct of a clinical research trial comparing anti-psychotic medication response in mentally ill

participants along with prayer intervention, in contrast to mentally ill participants having only prayer

intervention in a prayer camp in Ghana (1). The study or trial participants of persons with mental

illness (PWMI) in this instance included a number of chained PWMI, a situation that raised issues of

the ethical concern in two commentary articles in the same issue of the BJP (2) (3).The article as

published in describing the trial site, a prayer camp said among others that the camp mission

statement was to *“set free those held captive by satan....through its ministry of fasting and prayer”*

(1). This particular study was duly registered with study # NCT02593734 on the registry of clinical

trials in the United States of America ([www.clinical](http://www.clinical) trials.gov). Granted the article was of interesting

reading, my post-reading thoughts were as follows; (a) the normative ethical problems the study

raised, (b) the scientific validity/utility of the trial against the background knowledge of known

effectiveness of anti-psychotic medication, as well as the well documented intertwined problems of

chained PWMI in prayer camps and ethnoanthropological beliefs of disease causation prevalent in

Ghana, and (c) considering the study population and setting, the research ethics challenges of

obtaining valid informed consent from the participants.

When it comes to clinical research in resource-poor countries including sub-Saharan Africa (SSA)

countries, various challenging factors have been identified from the field of research ethics including

but not limited to the issue of research participants informed consent (4) (5).Ghana is no exception

to some of these research ethics challenges (6) (7). In this particular article by Ofori-Atta et al (1) I

will focus primarily on the study setting and method considering the context of psychiatric care and

research on PWMI in SSA country settings (and especially Ghana), and its ethical implications.

**Mental healthcare/policy, illness causation, PWMI and prayer camps: The Ghana situation.**

Going back from the early documented history of the evolution of mental health/psychiatric

practice in Ghana from the mid-1800 (8) (9) and the coming into law on 2nd March 2012 of the

Ghana mental health act, [Act 846]/ (MHA 846) (10) with the subsequent setting up and

inauguration on the 19th of November, 2013 of the Ghana mental health authority; Ghana hopefully

is moving towards bringing mental health practice (and hopefully the plight of PWMI), in line with

mental health practice norms of developed/high-income countries (11). Unfortunately though as at

the time of writing the dream of attaining such a mental healthcare status in Ghana despite the

passage of MHA 846, is more of a dream in the pipeline waiting on the legislative instrument that

will inject financial muscle to back up the act and activities under the act (12).This leaves the Ghana

mental health authority in the position of a lame authority at this time. The current situation is

compounded by donor financial assistance for country mental health activities being curtailed,

resulting in instances of non-admission of PWMI in need of psychiatric admission, premature

discharge of admitted PWMI from the few existing psychiatric inpatient hospitals, chronic shortages

of psychotropic medications to treat psychiatric in/outpatients, pay disputes with strike threats by

aggrieved mental healthcare professionals (MHPs) etc (13).

Adding to the quagmire of a poorly resourced mental health authority overseeing and supervising

mental healthcare provision and hence the optimum well being of PWMI is the pervasive problem

of the Ghanaian perception of locus of control/cause of mental illness. The pervasive thinking as to

the cause of illness and more so mental illness continues to be pre-occupied with spiritual causes,

witchcraft or curses (14) (15); with the urge amongst families of PWMI to consult on a good number

of instances spiritualists, traditional healers, witch doctors etc, rather than primarily with allopathic

mental healthcare professionals. Numerous studies back this ethnic-anthropological hypothesis up,

even in current times (14) (15).Against this ethnic-anthropological belief/hypothesis of causation of

mental illness has thrived the still existing practice of “prayer/healing camps” role in the community

“management” of PWMI (including instances of chaining of PWMI in some of these camps); about

which a number of articles have been written (16a-16b) (17) (18).

**Ethical implications of a clinical trial in the setting of a prayer camp with chained PWMI residents.**

Severely mentally ill patients constitute a vulnerable group by reason of stigmatization associated

with the illness (19), and in some cases as a consequence of their secondary and temporary (or in

some cases enduring) diminished mental capacity to make informed decisions (20). In the situation

PWMI find themselves in then persons working with them like health care professionals (HCP),

informal carers, friends etc need to protect the best interests of PWMI while they remain impaired,

in order that they are not taking advantage of. This is a duty of care obligation for HCP, especially

for mental health professionals (MHP) this should be a prima facie duty. In this situation a fall back

to philosophical medical ethics/normative ethical theories to buttress my thought may be helpful.

In the context of Kantian (deontological) ethics HCPs’ have a duty to manage PWMI as equals within

the moral kingdom in so far as there is no conflicting other obligation(21). On a

consequential/utilitarian level MHP in all ways possible should contribute towards PWMI

“maximizing their happiness” (22)or promotion of their value as a consequence of the care they give

to PWMI.

Under a virtue/care ethics paradigm, HCPs’ are supposed to ensure that PWMI incapacitated by

their illness be cared for and protected in order that they do not “fall through the web of

vulnerability” (23). Using a dignity and rights paradigm, PWMI need not lose their dignity as their

personhood is not diminished as a being mentally ill, and their human rights need to be protected as

human persons (24) (25). Without doubt considering the four principles paradigm (26) PWMI should

have their autonomy respected (including within a legal framework), they need to be protected from

harm (beneficence) and not be subjected to harm (malfeasance), and they should be treated in a

just manner. In considering these normative ethical theories/paradigms within a therapeutic setting

though, one should as always in medical ethics take into consideration the care context. Surely in the

face of most normative moral considerations chained PWMI in prayer camps as in this example of

the mentioned study (1)are being deprived of their personhood and moral attributes. In relation to

research ethics again one needs to consider the specific issues/problems in relation to research in

developing or poorly resourced settings and be mindful of guidelines pertaining to the conduct (or

means) of trials without sacrificing participants to satisfy the goal or ends of the trial (27) (28).

Otherwise put in the case of the chained PWMI in a prayer camp in Ghana (1)considering the

pervasive ethnoanthropological basisof stigmatization, the medication trial was not necessarily the

intervention needed to free the chained PWMI. A similar thought was raised by one of the

commentators regarding the trial article (3). Additionally in case of trials involving participants some

of who may lack capacity as was the case of this trial article (1)specific attention will need to be paid

to some core principals of research with such subjects who may lack capacity(29).

**Discussion**

The challenges of psychiatric care of PWMI in resource-poor SSA countries is well documented (30)

The challenges facing mental health care delivery in Ghana a country in SSA is no exception to those

of other SSA countries (12) (13). When it comes to psychiatric research in resource-poor countries

(including Ghana) there are challenges as identified earlier on (4) (6) (7). That said the trial as

written about in the article (1) probably should not have been conceptualized/executed as is for

the following reasons: (a) there is ample scientific evidence to date that demonstrates that

psychotropic medications at the appropriate doses in large part lead to amelioration of symptoms in

PWMI in general (31), this is supported by epidemiologic data from resource-poor settings too (31).

(b)The issue of chaining of some PWMI in Ghana has been going on for some time and have been

written about prior to the said trial (15) (17) (18).(c) PWMI get sent to some of the prayer camps and

get chained not because psychotropic medications do not work pharmacodynamically but rather for

other reasons, principal among them being (i) ethnic-anthropological based reasons (14) (15) (17)

(18) (ii) stigmatization leading to some PWMI being disowned by families (32), (d) hitherto poorly

administered national mental health policies/programmes, with an apparent national lack of

will/interest (12) (13) (arising from stigmatization?) and other non-enumerated causes besides

availability/access to psychotropic medications. It is therefore refreshing that one of the

commentaries in the BJP of January 2018 on the published article, raised the point that helping

PWMI (especially chained PWMI) is not all about medication (3). Against the background of the

immediate causes alluded to, a qualitative outcome driven research by MHP not on PWMI chained

or unchained, but rather cohorts from the general population, targeted cohorts on families with

PWMI, prayer camp operators etc need to be done.

These qualitative research activities if done in my view will enable MHP/ HCP to fully appreciate and

understand the cognitive themed basis of the population beliefs in order to better inform

evidence driven community belief reduction/ablative interventions, rather than quantitative

outcome based research on PWMI, which rather may place the dignity and rights of PWMI under

threat. As to the specific practice of restraining of PWMI, I have to mention that in even in high

resourced countries with “advanced mental healthcare systems/policies/laws” there is still a disquiet

even among MHP/HCP where time-limited restraint use becomes necessary in admitted PWMI in

mental health units, even though such use of restraint is done within practice guidelines and is time-

limited, with oversight from mental health care regulatory bodies and safeguards (33) (34).

In the specific situation of some chained PWMI within prayer camp settings in Ghana, granted this

practice has been written about there has not been targeted enforced safeguards or laws barring

these practices. Additionally, on a national policy level there appears to be a lack of will in the past,

and even in the present with the passage of a mental health act. A fleeting attempt was made by

some executive members of the Ghana mental health board recently to “unchain some of those

chained PWMI in a prayer camp (35). As a Ghanaian born psychiatrist and bioethicist with working

experience in both higher income and lower and middle-income countries (LMIC), the research

paper (1)sets off alarm bells for me in terms of psychiatric care and mental health ethics.

**Conclusion:**

Psychotropic medications including anti-psychotics have already been proven to be efficacious in

patients with psychosis and psychotic-like illnesses, as opposed to prayer only intervention (31). In

addition there is evidence of utility and therapeutic efficiency of psychotropic medication when used

in resource-poor countries (32).PWMI, especially in SSA countries including Ghana constitutes a

vulnerable group due to among other things stigmatization (36). Considering their vulnerability and

in some cases impaired ability to give informed consent (24) MHPs’/HCPs’ including mental health

researchers, should in their interaction with PWMI ensure that the PWMI best interest is paramount

when they are accessing service or being made research subjects. A parallel can be drawn in this

case from the international convention provisions on the responsibility to protect (R2P) paradigm,

on the role of the international community’s duty to intervene in individual sovereign states when

the particular state fails to protect a minority within the particular state from internal acts of

extreme pervasive aggression (37). This parallel duty of care in line with the R2P paradigm calls on

MHPs’/HCPs to have a responsibility to protect the PWMI under their care or as research subjects,

and is well along the care ethic paradigm of protecting PWMI from falling through the web of

vulnerability (23).

On a governmental level/policy level where the practice of chaining PWMI in various settings in

Ghana is concerned, the government owes PWMI the governance duty of care and R2P through

enacted and enforced legislation so that this abhorrent practice is eradicated for good, while

ensuring appropriate basic care for PWMI. Other national-level measures should include the

necessary national political will manifested through appropriate targeted legislation against the

practice of chaining in any form, intense media awareness campaign against the practice of chaining

using evidence-based ethnic-anthropologic knowledge, incorporation of ethnic-anthropologic

debunking cognitive behavioral approaches in allopathic therapeutic settings, as well as the use of

churches and non-governmental organizations (NGOs). To paraphrase from Harry Truman a society

is to be judged by how it treats its weakest members.

**Disclosure:**

None to declare.

**Authorship declaration:**

The author is accountable for all aspects of the work in ensuring that questions related to the

accuracy or integrity of any part of the work are appropriately investigated and resolved.

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