

MENTAL HEALTH PROFILE (GHANA) 2003

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BRIEF HISTORY

Legal backing to mental health activities started with the enactment of the Lunatic Asylum Ordinance in 1888 signed by the then Governor of the Gold Coast, Sir Griffith Edwards. Before this period, the mentally ill were found roaming in towns, villages, bushes and some locked up either in their homes or restrained by native doctors.

With the enactment of the ordinance, those who were found to be mentally ill were labelled "insane", arrested and put in a special prison in the capital Accra. By the beginning of the 20th Century, this prison had become full and therefore a facility named "The Lunatic Asylum, presently known as the Accra Psychiatric hospital was built in 1906.

The first psychiatrist south of the Sahara Dr. E.F.B. Foster, a native of Gambia was posted from the colonial office in London to the Accra psychiatric hospital in 1951. He transformed the Asylum into a hospital in conformity with the world wide changes at that time. He initiated changes and training of doctors and nurses who became trainers of trainers. He also arranged for a number of doctors to specialize in the field of psychiatry abroad.

The training of Qualified Registered Mental Nursing (Q.R.N.) was started in 1952 by Mrs. Higgison, a British national. The first trained mental nurse, Mr. L.L. Tamakloe joined the training school in 1965.

The Ghana Medical School started in 1962 with the inclusion of psychiatric undergraduate training.

The appointment of Doctor Asare, a UK trained psychiatrist, coupled with interest from the Head of State in 1983, resulted in the setting up of a committee to advise the Government on improving psychiatric services in the country and especially in the Accra psychiatric hospital. This was followed by the creation of the Mental Health Unit within the Ministry of Health. It heralded a new era for psychiatry. Training of mental health nurses was enhanced in the early 1990's. Public awareness of mental health issues was intensified. A general drive to reduce the population of the Accra psychiatric hospital from 2,000 to 1,000 was achieved.

MENTAL HEALTH COMPONENTS IN THE GHANA HEALTH SERVICE

Mental health features at two levels- the institutional care and community mental health, popularly known as community psychiatry. The institutional care takes place in public psychiatric hospitals and some private psychiatric hospitals while the community component is practiced at the primary care level, championed by Community Psychiatric Nurses (CPNS).

a) Psychiatric hospitals

There are currently three psychiatric hospitals in the country namely,

- 1) Accra psychiatric hospital, built in 1906 with a capacity for 800 beds but currently accommodates 1200patients.
- 2) Ankaful psychiatric Hospital built in 1965 in the central Region of Ghana. With a capacity for 500 beds but has 150 in patients now. The reduction in the number of in-patients is due to dwindling number of nurses and doctors.
- 3) The Pantang hospital was hurriedly commissioned in1975 to decongest the Accra Psychiatric hospital. The original intention of the then Head of state Dr. Kwame Nkrumah who initiated the building of Ankaful and Pantang was to provide a Pan- African Mental Health Village for Research. It was a grandiose project that would have recruited experts from Africa. Currently the hospital has a capacity for 500 beds but accommodates 450 patients. It has a vast land with a number of uncompleted wards, bungalows and junior staff accommodation left in the bush.

Both Ankaful and Pantang have nursing training schools attached, producing Registered Mental Nurses.

b) Other psychiatric services

There has been a policy of creating beds in the Regional capitals for psychiatric cases. Since this policy was formulated, some beds have been created in **five** of the ten Regions of Ghana even though each of the other five Regions provides beds in medical wards for psychiatric cases.

10 beds have been provided in Volta Regional Capital, Ho in their Regional General Hospital.

15 beds are available in Ashanti Regional Capital Kumasi at the main General Hospital (Komfo Anokye Teaching Hospital).

10 beds have been also provided in the Upper West Regional Capital Wa
Indeed a ward with **22** beds has been completed to accommodate psychiatric patients at the Regional Hospital at Sunyani, the capital of Brong Ahafo Region.

.Eastern Region with its capital Koforidua has provided **20** beds in its Regional hospital for psychiatric patients which would function in 2004.

c) Private services

There are two private hospitals in Kumasi Ashanti Region –**Pankrono Neuro-Psychiatric hospital and Adom Clinic at Santase.**

In Accra, there is one private hospital –**Valley View Clinic** and in the Port city of Tema, **The Alberto clinic.** All the private clinics are manned by psychiatric specialists except Adom Clinic which is manned by an experienced nurse.

d) Activities of psychiatric Hospitals

Each of the hospitals undertakes assessment treatment and has Rehabilitation facilities for long stay patients.

They also offer both in and out-patients facilities. In the Accra psychiatric hospital, there are a few patients who attend the Occupational Therapy Department as day patients.

Ankaful and Pantang hospitals are located in a rural setting and therefore provide out patient cover for primary health care, physical ailments including Maternal and child Health.

The Accra psychiatric hospital has an **overcrowded forensic facility for both men and women in two separate wards .Postgraduate and undergraduate medical training takes place mainly at the Accra Psychiatric Hospital. Ankaful is accredited for Diploma in Mental Health Training.**

Various types of assessments and counseling are undertaken by clinical psychologists.

All of the psychiatric hospitals are used for nursing affiliation programmes, social welfare training and training of clinical psychologists to the Masters Degree level.

The Department of Psychiatry which was located at the Accra Psychiatric Hospital since the establishment of the Ghana Medical School, has been relocated to Korlebu ,the main Teaching Hospital in Accra. Out patient service will start from 2004. It is our hope that beds will be provided for in-patient care in the nearest future

Epidemiology

Given the absence of hard community based data for mental illness in Ghana it is necessary to follow the normal convention of extrapolating from WHO estimates. Thus:

25% of the population suffers from neuro-psychiatric conditions during their lifetime.

- 10% of any population is suffering from neuro-psychiatric conditions at any time.
- 1% of that population is suffering from severe mental illness

(World Health Report 2001 – Mental Health: New Understanding, New Hope).
 Given the total population of 20 million people in Ghana the following should be true:

- 5,000,000 will suffer from neuro-psychiatric conditions during their lifetime.
- 2,000,000 will suffer from neuro-psychiatric conditions at a given time.
- 200,000 will suffer from severe mental illness.

STATISTICAL RETURNS TO THE ACCRA PSYCHIATRIC HOSPITALAL THE MAJOR PSYCHIATRIC HOSPITAL

JANUARY - DECEMBER 2000

AGE	ADMISSIONS		DISCHARGES		DEATHS	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
0-1YR	0	0	0	0	0	0
1-4	0	0	0	0	0	0
5-14	6	2	1	0	0	0
15-44	1944	1314	1224	810	53	34
44-59	213	238	185	163	22	18
60 +	70	59	37	27	18	10
TOTAL	2238	1613	1447	1000	93	62
GRAND	3851		2447		155	

JANUARY - DECEMBER 2001

AGE	ADMISSIONS		DISCHARGES		DEATHS	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
0- 1YR	0	0	0	0	0	0
1-4	0	0	0	0	0	0
5-14	16	8	3	0	0	1
15-44	1744	1234	1805	1030	30	12
45-59	294	210	183	178	24	10
60 +	80	84	35	29	18	10
TOTAL	2134	1536	1526	1237	72	33
GRAND	3670		2763		105	
TOTAL						

RETURNS JANUARY - DECEMBER 2002

	ADMISSIONS		DISCHARGES		DEATHS	
AGE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
< 1 YR	0	0	0	0	0	
1-4 YRS	0	0	0	0	0	
5-14YRS	7	6	6	4	0	
15-44YRS	1918	1179	1291	931	19	
45-59YRS	252	212	152	156	7	
>60YRS	63	93	41	69	11	
SUB TOTAL	2240	1490	1490	1160	37	
GRAND TOTAL	3730		2650		64	

RETURNS PANTANG HOSPITAL JANUARY –DECEMBER 2001

	ADMISSIONS		DISCHARGES		DEATHS	
AGE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
< 1YR	0	0	0	0	0	0
1-4YRS	0	0	0	0	0	0
5-14TRS	1	3	0	3	0	1
15-44YRS	590	357	376	243	6	3
45-59YRS	48	52	40	35	5	2
>60YRS	8	6	8	6	2	1
TOTAL	647	418	424	286	13	7
GRAND TOTAL	1065		710		20	

PANTANG HOSPITAL RETURNS 2002

	ADMISSIONS		DISCHARGES		DEATHS	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
< 1YR	0	0	0	0	0	0
1-4YRS	0	0	0	0	0	0
5-14	1	2	0	0	0	0
15-44	637	282	455	282	2	4
45-49	56	69	51	47	2	2
>60	5	10	8	8	1	1
TOTAL	699	362	515	338	5	7
GRAND TOTAL	1061		853		12	

More males are admitted than females. This is due to a number of factors. Females are over represented at spiritual and healing centers than males. Moreover, one of the major reasons for admission is the presence of aggressive behaviour which is more prevalent among male patients. Men also need women to take care of the home and are therefore treated more as out patients.

POOLED NUMBER OF ADMISSIONS FROM THE THREE PSYCHIATRIC HOSPITALS 2002

<u>TOTAL</u>	<u>MALE</u>	<u>FEMALE</u>
6,316	3,928	2,388

DISCHARGES 2002

<u>TOTAL</u>	<u>MALE</u>	<u>FEMALE</u>
4,972	2,916	2,056

TOP TEN CASES OF ADMISSION TO PSYCHIATRIC HOSPITALS 2002

1 Schizophrenia	-	1599
2 Substance Abuse	-	1101
3 Depression	-	736
4 Hypomania	-	629
5 Acute Organic Brain Syndrome	-	495
6 Manic Depressive Psychosis	-	343
7 Schizo –Affective Psychosis	-	284
8 Alcohol Dependency Syndrome	-	215
9 Epilepsy	-	191
10 Dementia		131

POOLED OUT PATIENTS ATTENDANCE OF THE THREE PSYCHIATRIC HOSPITALS 2001 & 2002

2001 - 77,688

2002 - 82,819

BACKGROUND INFORMATION OF DRUG RELATED COMMON ADMISSIONS TO THE ACCRA PSYCHIATRIC HOSPITAL Year 2000

Age group Of drug users	NO	Drug	NO	OCCUPATION Of drug users	NO
16-20YRS	46	Cannabis	366	Civil servants	24
21-30	254	Cocaine	2	Students	9
31-40	157	Heroin	7	Artisans	48
41-50	48	Alcohol	125		
51-60 +	21	Multiple	36		

DRUG RELATED ADMISSIONS TO ACCRA PSYCH. HOSPITAL YR 2000

ADMISSIONS		COCAINE		HEROIN		CANNABIS		ALCOHOL		MULTIPLE	
M	F	M	F	M	F	M	F	M	F	M	F
502	23	2	0	6	1	348	6	112	13	33	3
525		2		7		254		125		36	

DRUG RELATED ADMISSIONS TO ACCRA PSYCH HOSP. YR 2001

ADMISSIONS		COCAINE		HEROIN		CANNABIS		ALCOHOL		MULTIPLE	
M	F	M	F	M	F	M	F	M	F	M	F
571	19	2	1	7	1	368	3	130	10	62	2
590		3		8		371		140		64	

DRUG RELATED ADMISSIONS TO ACCRA PSYCH HOSP. YR 2002

ADMISSIONS		COCAINE		HEROIN		CANNABIS		ALCOHOL		MULTIPLE	
M	F	M	F	M	F	M	F	M	F	M	F
692	27	3	1	7	0	483	2	152	22	46	1
719		4		7		485		174		47	

From the three years data on substance abuse, it is evident that there is yearly increase in the total number of admissions .Cannabis admissions are higher each year and there are more men using drugs than women. This is cultural as Ghanaians frown on female drug users. The multiple drugs used involved cannabis, cocaine, heroin and alcohol.

Staff strength 2003

	ACCRA PSY.	PANTANG	ANKAFUL	
COMMUNITY				
Consultant Psychiatrists	6	2	1	-
Diploma in Psychiatry	1	1	1	5*
Nurses	250	146	55	160
Clinical psychologists	4 **	-	1	-
Medical Officers	4	1	-	-
Medical Assistants	-	1	1	-
Occupational Therapists	-	1	-	-
Social workers				
Other Para medicals	256	170	62	-

***Holders of diploma working in the 5 Regions assist the Community psychiatric nurses in Primary health care activities. They are based in General Hospitals.**

**** Two of the clinical psychologists are on national assignments as Deputy Minister and the other as Director of counseling, National Reconciliation commission.**

COMMUNITY PSYCHIATRY

The community psychiatry nursing programme started in 1975 and evolved into community mental health with the changes involving the enrichment, definition and involvement of medical personnel. The programme which was initially vertical, was integrated into the mainstream of health care delivery particularly at the primary health care level from 1986. The community psychiatric nurses have been our front line workers within the primary health care teams. They belong to the Budget Management Centers where they plan their activities to be included in the activities of the sectors where they are posted.

About 160 community psychiatric nurses have been trained and have been deployed in all the 10 Regional Capitals with their presence in 56 out of the 110 districts. The districts without community psychiatric personnel are covered through outreach programmes by the nearest facility with community psychiatric nurses. Currently, only about 132 are at post in 52 districts.

DISTRIBUTION OF CPNS

REGION	DISTRICT	NUMBER OF CPNS
Greater Accra		
	Ga	1
	Dangbe West	2
	Dangbe East	Nil
	Tema	6
	Accra	23
Total	5	32
Eastern Region		
	New Juaben	6
	Akwapim North	2
	Yilo Krobo	1
	Manya Krobo	1
	Suhum Kraboa Coaltar	2
	East Akim	2
	Kwahu South	1
Eastern Reg. cont		
	West Akim	2
	Birim South	3
	Akwapim South	1
Total	10dist.	21
Volta Region	Keta	2
	Akatsi	2
	Ketu /Aflao	2
	Ho	5
	Kpando	2
	Hohoe	3

	Jasikan	2
	Kadjebi	2
	Sogakope	1
Total	9dist	21
Central Region		
	Komenda-Edina- Eguafo-Abirim	1
	Abura –Asebu- Kwamankese	1
	Awutu-Effutu-Senya	1
	Cape Coast	2
Total	4dist	5
Western Region		
	Shama Ahanta East	8
	Nzema	2
	Sefwi Wiawso	1
	Wassa West	1
Total	4	12
Ashanti Region		
	Amansie East	1
	Asante Akim North	1
	Sekyere West	1
	Amansie West	
	Sekyere East	
	OldTafo Urban center	6
Total	5dist + 1healthc.	9
Northern Region		
	Yendi	1
	Tamale Municipal	1
Northern Region cont.		
	West Mamprusi	1
	Regional hospital	3
Total	3dist + 1hospital	6
Brong Ahafo		
	Sunyani Reg. hospital	3
	Bechem	2
	Techiman	2
	Sunyani	1
	Berekum	2
	Nkoranza	1
Total	5 dist + 1 hospital	11
Upper West Region		
	Wa hospital	2

	Wa Municipal	1
	Nawdoli	1
	Lawra	1
	Tumu	1
Total	4dist + 1hospital	7
Upper East Region		
	Kasena Nankana	1
	Bawku East	5
	Bolga	2
Total	3dist	8
GRAND TOTAL	52dists + 4health facilities	132

52 out of the current 110 districts are covered by the Community Psychiatric nurses. The districts that have no CPNS are covered on outreach by the nearest district with CPN

FUNCTIONS OF THE COMMUNITY PSYCHIATRIC NURSES

- 1) Awareness creation and mental health promotion in the community
- 2) Identification of cases
- 3) Referral of cases to the next level of care or to specialist hospitals
- 4) Management of some cases including counseling
- 5) After care services including out-patient care in the Regions and Districts.

OTHER LEGISLATIONS

Substance Abuse Policy (formulated 1990) On substance abuse there are three main laws. The Narcotic Drugs Control, Enforcement and Sanctions Law (1990), PNDC Law 236 and Pharmacy & Drugs Act (1961).

National Mental Health Policy and programmes were formulated in 1994 and revised in 2000. (see annex)

National Therapeutic Drug Policy/Essential List of Drugs is available and was formulated in 1986

Mental Health Legislation The NRC Decree 1972, Mental Health Law, was revised in 1992 and 1995 but has not been rectified by parliament as yet. The mental health law, though an improvement on the Mental Health Act, puts a lot of responsibilities on the head of the institution of the psychiatric hospital which was mainly the Accra Psychiatric hospital without taking into consideration the presence of other psychiatric hospitals and psychiatrists in the system.

It is also institutional based oriented with no consideration towards community mental health and rehabilitation of the mentally ill. Provision of facilities in general hospitals were not also considered and it does not deal with specific Human Rights of the patients. There are no laws governing the care of the mentally ill outside psychiatric hospitals particularly in traditional healing centers and spiritual homes.

PROGRAMME MANAGEMENT STRUCTURE

Mental Health Unit

The Mental Health Unit is currently working as a separate unit within the Institutional Care Division of the Ghana Health Service. There are five other Divisions, namely, The Public Health, Human Resource, Projects Planning Monitoring and Evaluation, Hospital Administration and Support Services and Stores and Supplies Divisions.

The Mental Health Unit is represented at the Headquarters level by **the chief Psychiatrist and the National co-coordinator of community psychiatry.**

A unit Headquarters is located at the Accra Psychiatric Hospital.

The office of the Unit HQ comprises of:-

- A) Administration-General
- B) Personnel management
- C) Procurement team
- D) Transport management

a) Roles of the unit

- Develop policies towards diagnosis, treatment and Rehabilitation of people with Neuro-psychiatric conditions.
- Develop Strategies to improve on awareness of mental and neurological disorders.
- Initiate Research

b) Functions

- 1) Monitor Specialist –Tertiary Mental Health Care
- 2) Develop and improve on Community Mental Health including After Care
- 2) Human Resource management
- 3) Quality Assurance
- 4) Intersectoral collaboration
- 5) Monitoring and evaluation of activities
- 6) Review, monitoring and implementation of policies and programmes

c) Psychiatric hospital level

There is a Director of the hospital who is assisted in administration by a **Hospital Administrator, a Deputy Director of nursing service and a Senior Pharmacist.**

d) Regional level

Mental health staffs in the Regions have heads known as the co-ordinators of the community psychiatric nursing programmes and who have offices in the Regional capitals.

The rest are based in the Regional hospitals where they are accountable to the BMCS (Budget Management Centers) there. They are expected to include their budgets in the BMCS.

The Regional heads attend the Regional Health management Team (RHMT) meetings.

- They ensure that mental health receives its share of funding.
- They also supervise the CPNS in the Regions and the districts.
- They train and work with other PHC workers including trained volunteers at all levels.

e) District level

The staffs at the district level also work under their BMCs.

They are however monitored by the Regional coordinators. The district level CPNS work closely with DHMTs and the sub –districts. They supervise the volunteers and work closely with the providers who have been trained .to manage minor psychiatric disorders

LINKAGES

The mental health unit works closely with some NGOs. "Friends of the psychiatric hospital", an NGO was established in the middle eighties of the last century. They are a group of women from churches and voluntary organizations who have come together to help the psychiatric hospital. Each of these groups has adopted a particular ward in the hospital which they visit and help in diverse ways. They came to help the hospital when there was famine in the country leading to malnutrition and high rate of deaths in the hospital. This NGO raises funds for some projects in the hospital annually.

An NGO, "Family Support group" was established in the year 2002 through the efforts of The chief Psychiatrist with support from V.S.O. The group has been helping families of discharged patients through counseling and home visits.

For the past one year, the mental health unit has been working closely with an NGO **BasicNeeds** which is based in the Northern part of Ghana. BasicNeeds has been working with our CPNS in the Northern sector and has also organized specialist outreach clinics to remote parts of the Northern Region. A specialist from Accra has been involved with these outreach clinics since 2002.

Ministry of Education and Ghana Education Service

Mental health features strongly in school health programmatic their resource books mental health contributed to alcohol and substance abuse. Mental health officers are also often invited as resource persons on some educational programmes

Department of Social Welfare

The Department of social welfare works closely with mental health unit in the area of screening vagrants on the streets and Rehabilitation. There is a mental health officer working closely with the community Based Rehabilitation managed by the Department of Social Welfare

Ministry of the Interior

The Narcotics Control Board ,the Prison Service and the Police Service are under this Ministry. A member from the mental health unit serves on the Narcotics control Board. There is close collaboration with both Prison authorities and the Police in case assessment, management and Rehabilitation.

Ghana Health Service and the Ministry of Health

Mental health unit features under the Ghana health service and participates in meetings for **Senior managers and Regional Directors**. Policy directions are also formulated at the Ministry level with mental health inputs.

Budgeting and reports are included in the institutional care at head quarters level. The three psychiatric hospitals have separate budgets under Tertiary Institutions. The mental health unit also works closely with the **health promotion unit** to create awareness particularly in the celebration of World Mental health Day, Drug Abuse Day and other special mental health community programmes. Health promotion Unit had also helped in the preparation of handouts for the general public.

The mental health unit also collaborates with the **health Research Unit**.

Donor Partners

Mental health unit benefits indirectly from the centralized donor fund which is distributed to BMCs. The mental health however over the years had benefited from direct WHO funding to support our programmes. Among the important projects have been the integration of mental health into the PHC Programme, the training of primary care workers, provision of motor cycles for the community psychiatric programme. the support of awareness programmes of the international day celebrations and funding of the on-going training of volunteers and providers at the sub-district level.

IMPLEMENTATION OF THE GLOBAL AND REGIONAL WHO STRATEGY FOR MENTAL HEALTH

i) Health Policies

- i) Mental health is included in the overall programmes of the Ghana health service. The mental health policies have been updated and a majority of the policies have been implemented and some of the policies are in the process of implementation.

Concerns regarding coverage and availability of mental health personnel at lower levels of care delivery are being addressed to a large extent. We are however struggling with attrition of staff through mass exodus for greener pastures, retirements and resignations.

The Government has sponsored training of 10 doctors to obtain Diploma in mental health to assist management of psychiatric cases in the Regions. Unfortunately due to shortage of psychiatrists three of these doctors are working in the psychiatric hospitals but the programme has been suspended to give way to the local postgraduate training in Ghana.

Training of non-mental health workers volunteers in communities

This training is ongoing at PHC level with the view of integrating mental health in the mainstream of health care delivery.

At some district and Regional levels, mental health is represented in the health management teams. The mental health workers belong to the budget management centers and are therefore included in their composite budgets.

ii) Development of National Programmes.

National programmes are developed with objectives that mental health has an input. The mental health activities addressing these objectives become basis for annual budget.

The activities are reviewed and updated in a multidisciplinary setting.

Prevention and control of substance abuse is centralized through the Narcotic control Board. The activities of Demand reduction are championed by the ministries of health, social welfare and education. Management of substance abuse continues to be in psychiatric hospitals. It is being proposed that treatment and rehabilitation facilities outside psychiatric hospitals be established.

Mental health week and international day against drug abuse are celebrated every year. These celebrations are used to create awareness and also involve communities in mental health activities.

Depressive illness and suicide prevention is receiving attention through awareness creation and early identification of people suffering from it.

“Epilepsy out of the shadows”- Epilepsy is one of the conditions shrouded with mystic causes and feared by many. Awareness is being created to free epileptic patients from lack of attention and being managed by spiritualists and quack doctors. It has been identified that there are a lot of epileptics in places where cerebro-spinal meningitis and onchocerciasis are endemic.

iii) The Ghana Health service has a standing committee that organizes, implements and sees to the observation of international days including world mental health days which fall on the 10th of October. There is a budget line for this celebration which is prompted by the unit head and his team. It is often very elaborate and involves the top hierarchy of the ministry of health and other service personnel. Community activities and mass media programmes are included.

iv) There is a law on drugs and narcotic substances. But the mental health Law of 1972 has not been reviewed yet. This is something that needs to be addressed. There have been two unsuccessful attempts to review the law in 1992 and 1996.

v) There is a mental health unit head office created, furnished with personnel coordinating activities of mental health in the country. At the Ghana health service Headquarters level, mental health is regarded as a separate unit under Institutional Care Division. It is our hope that mental health will be upgraded in future to a division to reflect its scope so as to receive better attention.

vi) The Ghana Health service continues to absorb the financing of mental health. Treatment as in or outpatient is free. Drugs are also provided free of charge to patients.

vii) The capacity building has not received much attention. Apart from psychiatric nurses who are being trained locally, doctors are not showing interest in the field. The mass exodus of nurses and other mental health personnel from the country has affected the manpower situation of the unit. A recommendation is being made for some lay people to be given orientation to assist professionals on the wards just as we are training volunteers.

viii) Research culture is being encouraged.

There is an almost completed research into relationship between HIV and IDU and risky behaviour among drug users in Ghana.

A research into why doctors do not want to specialize in psychiatry

ix) Community based psychosocial interventions have been addressed on ad hoc basis. A project has been written for consideration to address rehabilitation in the community, aftercare services for those with chronic mental illness and also to provide information and counselling centre on pilot basis.

ONGOING INTERVENTIONS

- 1) There has been a steady attrition of staff particularly nurses in the psychiatric hospital through deaths, retirements, resignations and seeking for greener pastures elsewhere. Stigma has also been a problem confronting the service which does not encourage people from entering the field of mental health. It became obvious that if some measures were not taken, the mental health services would be greatly affected.
- 2) It was also felt that if some members of communities (volunteers) were given some training in the identification of the mentally ill and were empowered to assist by referring such cases early, they would reduce the burden of the CPNS in the districts.
- 3) There was the need to train providers in the sub-district who will receive the referrals from the volunteers and also to link the CPNs, volunteers and providers together so as to create a network of mental health service in the sub-district.

The above assumptions lead to the implementation of a special project to involve communities.

The Nations for Mental Health Project- Pilot Project Sponsored by WHO (1999)

This project was piloted in two districts in the Eastern Region of Ghana (Yilo and Manya Krobo Districts). The project is aimed at developing community-based services in the districts with activities initiated from the sub-districts. This is response to the national policy of decentralization of activities. The project is based on the conviction that mental health promotion and the prevention of mental illness can be undertaken in primary care setting and that if communities are made aware of symptoms of mental illness and equipped with some skills, they may be able to participate in the prevention and to some extent manage some types of problems concerning mental health.

This project fulfils the policy of the Ghana Health Service of increasing access, reducing stigma, decentralization of mental health care and community participation.

Methodology

The two CPNS in the Manya and Yilo districts were asked to enter their sub-districts and allow the opinion leaders and the District Assemblies assist in selecting volunteers from the six sub-districts in the Manya District and five sub-districts in the Yilo District.

Training manuals for the volunteers and providers were developed. Two days training for the volunteers aimed at helping them identify common minor and major neuro-psychiatric disorders, was organized. The participatory learning technique was used and simple English language mixed with the local dialect of the area was used.

At the end of the training, volunteers were expected to know who they should refer as suffering from mental illness to the next level of care or to the CPN or a specialist as the case may demand particularly with reference to the choice of relatives of the patients.

Inventory of providers of health care including private facilities was taken by the CPNS in consultation with District Director of Health Services.

The providers who were mainly Medical Assistants, a few Doctors, Public health nurses and Midwives in charge of health centers and hospitals also had two days of orientation. They were taken through management of a range of psychiatric disorders including psychological and physical management of those disorders.

At the end of the training, it was expected that the providers would be able to handle some moderate types of mental disorders in their clinics and know who and when to refer.

The main indicators for this project were the number of cases seen by the volunteers per annum and the inclusion of mental health returns in the District reporting systems to the Regions. The number of cases registered by the providers and collated by the CPNS was another indicator.

So far, six districts that is, Yilo Krobo, Manya Krobo, In the Eastern Region; Amansie East, Sekyere West, Offinso and Ashanti Akim in the Ashanti Region have benefited from this project. The project would be scaled to three other districts in 2004. **The Ghana Health Service has provided funds to scale up the training to three districts –two in Greater Accra Region and one in the Central Region.**

So far, 184 volunteers and about 130 prescribers have been trained in 6 districts. The volunteers are Community Based Surveillance workers who are adding mental health to their surveillance activities. The Ghana Health service is seeking for funds to train more community workers in the poverty alleviation budget and frame work

Orientation of Doctors and Nurses in the Regional Hospitals

In order to free the community psychiatric nurses to function effectively in the community and also to ensure that most of the mentally ill are treated in the Regions, Doctors and nurses will undergo separate orientation so as to be able to handle some of the psychiatric cases.

This project would take off in the year 2004..The **Indicator for this project would be the number of psychiatric cases managed by the Regional Hospitals.**

Community Mental Health Project

1) This is a project which has been prepared by Basic Needs and The Ghana Health Service which is aimed at de-emphasizing on institutional care and empowering the communities to look after themselves with support from trained personnel The project is based on the experiences gained from the Nations for mental health project and the ongoing community work by Basic Needs in the Northern Sector. It has components of Rehabilitation, income generating activities by both the families of the mentally ill and recreational and social support for the mentally ill. This would involve provision of **"a club house" known as (Tisampa –a meeting place in Dagomba) where patients can bath, have at least one meal a day, play and in the process, receive some medication where necessary** .The club house would be started in Tamale and replicated in Accra. The project also has a training component for volunteers and providers and also appointment of focal persons for the various communities This project is being funded by Basic Needs and supported by the Ghana Health Service.

2) Funding is being sought for **a Community Programme Based on Resource Realities** which has been developed.

The main objectives are:-Access to treatment within the community and a return to economic activity on a sustainable basis.

A rolling community mental health and development programme will be established to cover 10 Regions in Ghana for five years with a zonal approach.

ZONE	REGIONS	POPULATION	ZONE POPULATION
1	Upper East Upper west Northern	920,089 576,583 1,820,089	3,316,761
2	Ashanti Brong Ahafo	3,612,950 1,815,806	5,428,756
3	Central Western	1,593,823 1,924,577	3,518,400
4	Volta Eastern	1,635,421 2,106,696	3,742,117
5	Greater Accra	2,905,726	2,905,726

In the approach to the problem, the overall aim of the mental health and development programme is to support mentally ill people living at home to take part in the development process of their community. By this we mean *the chance to take charge of their own life* for example the chance to take part in social functions, to be considered a suitable marriage partner and particularly the right to take part in work or small-scale income generation.

Based on the research and evidence arising from community based work in Northern, Eastern and Ashanti Regions in Ghana as well a model is proposed comprising of the following programme objectives:

1. Community Mental Health

To provide appropriate mental health care and treatment to mentally ill people living in the community.

2. Sustainable Livelihoods

To support mentally ill people and their families to earn an income either through work or by involvement in income generation schemes.

3. Research

To research the situation of mentally ill people in the community (this implies hard data collection and “soft” collection of materials leading to consumer involvement in the research itself).

4. Capacity Building

To build the capacity of mentally ill people, their families and partner organizations in order to involve them in the development process.

5. Management and Administration

To provide an efficient administrative, financial and evaluative service for the programme.

6. Inter-sectorial or inter-agency collaboration

To develop an effective inter-sectorial collaboration at district, regional and national level.

In describing the Programme in detail each objective and output is described in terms of indicators of success and their measurement.

The overall aim of the programme is to develop a community mental health and development programme so as to provide access to treatment within the community and a right to economic activity on a sustainable basis.

Objective 1	Indicators	Measurement
<p><i>Community Mental Health</i> To provide appropriate mental health care and treatment to mentally ill people living in the community.</p>	<p>By end 2007 complete system of community mental health care operating in the community managed by locally trained staff and lay people.</p>	<p>Outreach service monitoring records and medical assessment records. Programme monitoring data.</p>
Outputs	Indicators	Measurement
<p>Professional intervention and stabilization of mental illness within the community itself.</p>	<p>By year 2007 a minimum of 500,000 families recognizing the illness and seeking professional intervention. By year 2004, 5,000 workers recognizing mentally ill people and referring for intervention.</p>	<p>Programme monitoring data e.g. medical records, Quarterly reports Annual reviews.</p>
<p>Greater understanding and awareness of mental illness amongst mentally ill people, their families and communities.</p>	<p>Mentally ill people participating in everyday activities of the family and community. Community more tolerant of mentally ill people. Reduced incidence of human rights abuse against mentally ill persons, e.g. being tied, chained, beaten etc.</p>	<p>Quarterly report of the work and activities of each mentally ill person. Production and dissemination of life stories. Increased visibility of persons with mental illness in the community. Interviews with mentally ill people.</p>

Objective 2	Indicators	Measurement
<p><i>Capacity Building</i> To build the capacity of mentally ill people, their families and government and voluntary sector organizations in order to involve them in the development process.</p>	<p>By 2007 a minimum of 495,000 mentally ill people and their families involved in the development process. By 2007 250 voluntary sector partners strengthened in order to continue working with mentally ill people.</p>	<p>Baseline information and programme monitoring data providing numbers of people involved in the programme. Annual reviews and evaluation beginning of year 3.</p>
Outputs	Indicators	Measurement
<p>Mentally ill people and their families form Self-Help Groups (SHGs).</p>	<p>By beginning of 2005 self help groups formed.</p>	<p>Monitoring records Interviews and interaction through self help group. Ghana Health Service and Voluntary Sector Organizations reports and evidence from user led research.</p>
<p>Government and voluntary sector organizations trained in awareness of mental illness and the management of a community mental health programme</p>	<p>By end of 2005, 150 (voluntary sector – 50/year/zone) government and voluntary sector organization workers in recognizing mentally ill people in the community. By end of 2006, 150 (voluntary sector – 50/year/zone) government and voluntary sector organisations trained in the management of self-help groups.</p>	<p>Ghana Health Service and Voluntary Sector Organizations records of number of mentally ill people. Quarterly reports. Quarterly reports from Ghana Health service and Voluntary Sector Organizations with regard to training achievements.</p>

Objective 3	Indicators	Measurement
<i>Self Reliance</i> To support mentally ill people and their families to earn an income either through work or by involvement in income generation schemes.	Mentally ill people and their families enjoy an increased income.	Family income study produced and compared to baseline income indicators.
Outputs	Indicators	Measurement
Formation of savings and credit schemes.	By end of 2006, saving scheme established by the self help group. Families begin saving regularly.	Income generation report – evidence drawn from savings books.
Mentally ill people gain access to work.	Mentally ill people undertake skills training. Ghana Health Service and Voluntary Sector Organizations staff negotiate placement with work providers. By the end of 2006 a minimum of 5% of mentally ill people return to work.	Family income increased as reported by mentally ill people & families, through Ghana Health service and Voluntary Sector Organizations workers and described in quarterly reports. Also income study.

Objective 4	Indicators	Measurement
<i>Research</i> To research the situation of mentally ill people in the community.	By 2007 results of research are used to influence strategies of work with mentally ill people. Based on knowledge acquired the situation of mentally ill people shared with policy makers at local, district, country and international level.	Research programme documented and publications produced. The experience of mentally ill people is presented in reports, lobby material and court evidence.
Outputs	Indicators	Measurement
Deliver research skills to Ghana Health Service and Voluntary Sector Organizations staff and mentally ill people.	Training programmes established for: Enumeration and data analysis Listening skills for life story notation. Writing up research analysis	Empirical data produced in reports and documents and annual review Life stories produced for use both as therapy and advocacy purposes.
To produce research	Empirical and user led	Numbers of mentally ill

evidence in a variety of reports and other formats.	research programmes designed and implemented by the end of 2005.	people and family members verified in annual programme review. Life stories produced and disseminated as part of advocacy programme to influence policy.
Dissemination of knowledge and lessons learnt through implementation of programme.	Partnership establishes a knowledge management project. Year 1 – development and design of project. Year 2 and 3 implementation.	Life stories and process documentation published in paper form, on web site and communicated through other forms of media e.g. workshops, meetings etc.

Objective 5	Indicators	Measurement
<i>Administration</i> To provide an efficient administrative, financial and evaluative service for the delivery of the programme.	Reports produced on time containing relevant, reliable, accurate and comparable information.	Monthly reports from Government and Voluntary Sector Organizations. Annual Review against indicators and budget.
Outputs	Indicators	Measurement
Programme monitoring and evaluation system established to include the involvement of all stakeholders.*	System documented and staff trained. Monitoring undertaken on a monthly, quarterly and yearly basis.	Monthly reports from Government and Voluntary Sector Organizations Quarterly reports from BasicNeeds Annual Review Evaluation
Efficient administrative and financial system agreed with partners.	Administration and financial system in place.	Monthly Reports From Government and Voluntary Sector Organizations.

Objective 6	Indicators	Measurement
<i>Inter-sector or inter-agency collaboration</i> To develop an effective inter-sector collaboration at district, regional and national	Mental health forum formed to include MOH, Social Welfare Services, Municipal Assembly and Traditional Leaders.	Minutes of meetings Reports – quarterly. Invitations & Posters for meetings.

level.		
Outputs	Indicators	Measurement
Regular 3 monthly meetings at zonal, regional and district levels in place.	Timetable and Agenda for meetings produced.	Minutes of meetings Reports – quarterly. Invitations & Posters for meetings.
To produce a policy document about inter-agency working.	To ensure all offices adhere to policy.	Monthly reports of joint working. Quarterly reviews of all agencies involvement with mentally ill people.

In order to deliver a community mental health and development programme it is clear that whilst medical treatment in the community is essential it is only really one component amongst many. In seeking to enact the objectives described above the operational partnership is promoted as follows:

Strategy	GHS (Activities)	BasicNeeds (Activities)
Community Mental Health	Training Medical Prescribers (Medical Assistants) School Leavers- Care asst.	Organizational capacity building (patients, carers, groups, low level personnel)
Sustainable Livelihoods	Rehabilitation through self help groups "Clubhouse" concept	Income generation through partnership/group organizations
Research	Traditional Healers Data Prevalence Studies (Registration)	Traditional Healers Life Stories User Led Research Process Documents User Movement Consumer Groups
Capacity Building	Awareness and Advocacy Public Information	Groups of mentally ill people Carers GHS staff Mass Media
Management and Administration	Establishment of a management and administration centre headed by Chief Clinician	Field Project Management Day to day Management Financial Management
Inter-sectorial or Interagency collaboration	Social Services Traditional healers NGOs, legal services, Bilateral Cooperation	Social Services Traditional healers NGOs, legal services, Bilateral Cooperation

RELOCATION OF THE ACCRA PSYCHIATRIC HOSPITAL

This is a major project which is being supported by the Government. The project has been on the drawing board since 1975. Due to political instability, the project was shelved and it resurfaced in 1990. It was proposed that the hospital would be relocated to Pantang and Ankaful by the end of the year 2000. Serious attempts were made in 1997 by the Social Security and National Insurance Trust (SSNIT) to purchase the land which was considered to be in a prime area. Unfortunately, SSNIT backed out at the last minute.

Various reasons have been given to the relocation but the most plausible are, to reduce stigma, remove all the negative and primitive part of psychiatry and promote community mental health using the resources at our disposal.

The project is being revived by the current Government. This is a project set out to de-emphasize institutional care which will give way to out-patient clinics at Polyclinics and general hospitals. Some of the staff at the Accra Psychiatric Hospital would be given orientation in community work, counseling and Rehabilitation so as to fit into the Community Development programme. Others will be transferred to Pantang with some of the in-patients at Accra Psychiatric Hospital. It is hoped that more awareness would be created and both the staff and the community sensitized so as to implement this programme as humanely as possible.

RESEARCH

WHO funded a research into the prevalence and social consequences of substance(drug) abuse among second cycle and out of school youth which has been published in 2002 Some of the major findings of this work are that:-

a) Alcohol is the commonest drug used by the youth followed by cigarette and cannabis. Substances like cocaine, heroin, tranquilizers and amphetamines were rarely used by the youth.

b) The most startling finding was that a majority started using cannabis from between the ages of 8 and 23 years

ii A project on Knowledge Attitude and practices in mental health in three Regions is to be published

iii A research into the link between HIV/AIDS and substance abuse and Risky behaviours among drug users in Ghana is almost completed. This project sponsored by The United Nations Office on Drug Control has the Objectives of investigating IDU use in hospitals and psychiatric centers : Prevalence of HIV among drug users: the pattern of drug use among People living with HIV/AIDS and to ascertain the linkage between HIV and drug use.

CHALLENGES

DECENTRALIZATION OF MENTAL HEALTH SERVICES

There is a policy to provide psychiatric presence in all Regional Hospitals. This has been partly achieved by posting community psychiatric nurses to the Regions and also creating a post of PNO (psychiatry) at the Regional offices.

The stigma attached to mental illness and psychiatric hospitals has led to delays in and refusal of some patients to be attended to in these institutions. Consequently the need to provide psychiatric care in General hospital and other facilities in the community. The programmes that we have embarked upon are set out to help address this problem. The decentralization of mental health care, involvement of communities and other stake holders will be among the major challenges ahead.

Supervision of Mental Health Personnel in the Regions

Low manpower

The problem of supervision and lack of acceptance of nurses as therapists in the Regions has undermined the care of the mentally ill in the regions. Despite monitoring interventions, there are still problems in some regions. Consequently the training and recruitment of one-year diplomats in psychiatry will be in the right direction. The recruitment of clinical psychologists by the ministry will also enhance the activities of psychiatrists as well as promote the well being of the patients. The Regional directors are to ensure that the hospital superintendents adopt the units into their main stream of service.

The dwindling number of specialists and mental health workers will affect our projected activities and ways need to be found to train more personnel and neutralize the effect on the service.

It has become obvious that without an active recruitment drive and adequate incentives for mental health workers, we shall very soon be hit by an acute manpower shortage. With the expansion of community services, it will be desirable that each region nominates nurses for psychiatric training. Consequently it will be in the right direction if heads of mental health wings arranged with the guidance and counselling unit of the Ministry of Education to prepare JSS and SSS candidates for career opportunities in psychiatric training and such candidates shall be made to sign a bond to return to their respective regions. This will assist us in our attempt to offer a balanced coverage of care.

b) Situational Analysis

There is a need for situational analysis to ascertain the number of personnel required for the units. This is very important because the CPNS in the Regions may be capable of performing out patient duties alone and consequently in patient care may be shared between another cadre of psychiatric nurses and general nurses. The above programmes are to be accomplished in the short term.

c) District Level

Though currently there are a few psychiatric nurses in the districts, the full coverage of the districts will be realized in the long term that is within 10 – 20 years if the Government is able to address the exodus of nurses. However in the immediate future, where psychiatric nurses are posted, it is expected that they will have an office, part of which can be converted into outpatient/meeting room.

It is also expected that RMN qualified nurses will be at post to assist the medical officers in referring cases which require admission to the appropriate level of care.

It is important also that efforts are made by the District Medical Officer to absorb mental health personnel and avoid isolation of this cadre of staff.

2) A BOARD TO MANAGE MENTAL HEALTH

It is necessary that a board to oversee the affairs of mental health is established. The board would have broad functions of looking at funding for mental health activities, control of funds, looking into disciplinary matters and all other aspects of mental health delivery that would increase coverage and attract professionals into the field.

3) ESTABLISHMENT OF NATIONAL MENTAL HEALTH COORDINATING GROUP

After making the mental health institutions autonomous, the next line of action is to put in place that would support this autonomy.

As mental health is not adequately represented in terms of numbers at Headquarters level and consequently a lot of pressure is put on the Chief Psychiatrist, Their function would be specifically in the area of monitoring ,evaluation ,planning and co-ordination It is necessary that a technical coordinating group is established. This group will be in advisory position to the Government and would work closely with the Board.

4) PROVISION OF FACILITIES FOR THE MANAGEMENT OF SUBSTANCE ABUSE

The problem of substance abuse is escalating every year. Unfortunately due to the stigma attached to mental illness and psychiatric hospitals, drug abuser who do not regard themselves as being mentally ill avoid coming for help in the psychiatric hospitals. It is therefore necessary that a facility be provided for drug abusers who will not be mixed with the mentally ill where counselling and other social interventions can be administered to them.

5) TRAINING

The mental health sector has not attracted enough personnel. Lack of incentives and the discriminatory attitude of the public towards psychiatric patients and staff have acted as disincentive to recruitment.

There is a need to increase the number of student intake to the training institutions and also provide attractive incentives to retain the trained staff.

District Assemblies should sponsor students from their areas who would return to them after training. There should also be active recruitment of Psychiatrists.

There is a need for retraining the current staff in areas like counselling, social work, family therapy and Rehabilitation. This will help in implementing our community mental health programme.

6) MENTAL HEALTH AWARENESS

The success of our community and other progrqammes will depend to a large extent on the awareness that will be created for the community to participate and accept the mentally ill. Programmes to demystify mental illness and promote wide understanding of mental health issues will have to be pursued vigorously.

The health promotion unit and public health officers would have to be sensitized to include mental health in their awareness programmes.

Target information need to be prepared and appropriate methods of mass communication used to reach a wider population.

7) POSITION OF MENTAL HEALTH IN RHMT AND DHMT

Mental health workers are not uniformly included in the RHMT and DHMT. Their presence had depended on the popularity or curiosity of the mental health worker in the area. There is therefore the need to formalize inclusion of mental health workers.

8) TRANSPORTATION

Lack of transport features as the commonest problem among our staff in the Regions. Though WHO has supported the mental health sector with motorcycles for the community psychiatric nurses in the past, there is a need for the sector to be provided with vehicles that would enhance the work of mental health teams.

The concept of pooled resources has not been effective in some places where priorities are skewed towards MCH and Public health activities. Since mental health workers will have to travel to inaccessible places, mopeds will prove useful. However there is a need for a few four-wheel drives.

CONSTRAINTS

Inadequate funding

We need to find more NGOs to help and also sensitize other agencies to come on board and support some of the programmes financially.

Lack of personnel

To be able to run a comprehensive, humane and acceptable mental health programme requires an appreciable number of personnel which we do not have and therefore we need to strategize to find some solutions to this problem.

WAY FORWARD

- 1. Scale up training of volunteers and providers in the sub- districts**
 - a. Review the Mental Health Law to embrace Community Mental Health and Traditional practices**
 - b. Increase intake of students at the training institutions**
 - c. Intensify Awareness on mental health in the community**
 - d. Work closely with BasicNeeds and other NGOs to implement the community mental health programme**

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- Part time Senior Lecturer Ghana Medical School
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- Author in weekly newspaper Chronicle on Saturday "Your family life counselor"

ANNEX

MENTAL HEALTH POLICIES REVISED 2000

POLICY 1 - DECENTRALISATION OF MENTAL HEALTH SERVICES

MISSION STATEMENT:

To offer psychiatric care to all those who present themselves or are referred and promote good mental health for the psychological wellbeing of people living in Ghana.

Problem Statement:

Majority of people in Ghana travel long distances to receive mental health treatment at the three psychiatric hospitals; namely, Accra Psychiatric Hospital, Ankaful Hospital and Pantang Hospital which are located in the southern part of the country. Thus there is imbalance in the coverage of mental health problems in the country.

OBJECTIVES (1)

To provide facilities at the Tertiary and Regional Hospitals for management of Psychiatric patients.

REGIONAL LEVEL:

- (a) Establish mental health Units in all the Tertiary and Regional Hospitals
- (b) A psychiatric wing should be provided at all Regional Hospitals.
- (c) Each wing should be headed by a psychiatric diplomate/psychiatrist, Supported by a clinical psychologist and a minimum of 8 nurses including a PNO/SNO in nursing Supervisory role.

The Regional Head of Mental Health to the Regional Director of Health Services shall recommend and sponsor candidates from the region for training in mental health.

- (d) .nursing, psychiatry and clinical/counselling psychology who shall return to the region after training.
- (e) The Regional Director of Health Services, on the advice of Medical Superintendent/psychiatric diplomate shall be responsible for provision Of equipment and other logistics.
- (f) The Regional Director of Health Services shall also be responsible for the welfare of all grades of personnel in the unit.
- (g) Integration of Mental Health into Primary Health Care Programme.

DISTRICT LEVEL:

MEDIUM TERM:

OBJECTIVE (2)

To provide facilities at the districts for management of psychiatric patients.

- (a) An Out Patients Unit for the mentally ill and offices should be provided at every district hospital.
- (b) Outreach service for the mentally ill should be an integral part of the out patient unit.
- (c) Each unit shall be manned by a minimum of two community mental Health nurses, one of whom shall have the RMN qualification.
- (d) There shall be regular in-service training at the district level.
- (e) All patients who require admission should be referred to the nearest Regional hospital.
- (f) The annual budget of the Unit should be integrated in the master Budget of the District.

POLICY 2: NATIONAL MENTAL HEALTH CO-ORDINATING GROUP

In 1993, the Ministry of Health decided that Psychiatric Hospitals should be regarded as specialized institutions similar to the tertiary institutions; such as, Korle Bu Teaching and Komfo Anokye Teaching Hospitals. The specialized institutions will be regarded in the same way as a region with its secretariat and will report collectively to the Director General.

Although the 1990 – 1995 National Mental Health programme recommended the establishment of a national Mental Health Co-coordinating Council; so far, this has not been established and thus has delayed the implementation of the proposed national mental health programmes.

In view of this decision, and since the two tertiary institutions have been granted permission to establish Management Boards, it is recommended that a joint Management team to be known as National Mental Health Co-coordinating group should be established. It is also recommended that, the mental health institutions should have separate management boards.

Establishment

There shall be established by the Ministry of Health a National Mental Health Co-ordination group, which shall be the National advisory body to Government on policies regarding implementation of National Mental Health services in Ghana.

Membership:

1. Chairman appointed by the Minister for Health
2. Vice Chairman
3. Secretary
4. The core members shall be made up of representatives each from:
 - a. Ministry of Social Welfare
 - b. Ministry of Education
 - c. Ministry of Justice
 - d. Mental Health Association of Ghana
 - e. Ministry of Local Government
 - f. Ghana Medical School
 - g. Youth and Sports.
5. Chief Psychiatrist
6. Deputy Director of Nursing Services (Psychiatry)
7. Christian Health Association of Ghana
8. One consumer representative
9. Deputy director of Herbal Medicine
10. Member of Council of Psychologist

Terms of Reference:

1. Advise on mental health policies and services at National level.
This will include:
 - a. In-patient care
 - b. Community Mental Health Care
 - c. Rehabilitation
 - d. Clinical psychology
 - e. Forensic mental health care
 - f. Mental health for specialised groups; such as child/adolescents,
Substance abuse and the aged

2. To collaborate with other sectors on mental health services i.e. Ministries of Education, Youth and sports, Justice, interior, Local Government, Agriculture, Social Welfare and Mobilization, National commission on children and other Non-Governmental Organizations on Mental Health Service.
3. To advise on the welfare of mental health workers.

POLICY 3: TECHNICAL COORDINATING COMMITTEE

Problem Statement

At present, technical issues affecting Mental Health Services are addressed on ad-hoc basis, and this may be partly responsible for the apparent marginalisation of the mental health services.

Objective:

To establish immediately a formal Technical Committee which shall be responsible to the National Mental Health Coordinating group. It is a committee to deal with specific mental health issues.

Membership:

1. Chief Psychiatrist
2. Heads of Department of Psychiatry (UGMS/SMS)
3. A Clinical Psychologist
4. One Principal of R.M.N. Training Colleges of Pantang or Ankaful
5. National Coordinator of Community Mental Health Nursing
6. Occupational Therapist.
7. Psychiatric Social Worker
8. D.D.N.S. (Psychiatry)
9. A Senior Health Services Administrator

FUNCTIONS:

1. To revise and prepare training manuals as and when necessary.
2. To establish quality assurance mechanism in the service.
3. To provide mechanism for reviewing, monitoring and evaluating Mental Health programmes.
4. To establish relations with the universities and other training institutions in the provision of specialized care and research.

POLICY 4: FACILITIES FOR MANAGEMENT OF SUBSTANCE ABUSE

Problem Statement:

Many drug users are not coming for treatment because of the stigma attached to mental health institutions and also because there is no specific facility for treatment of substance abuse.

Objective:

To provide a comprehensive and multidisciplinary unit for substance abuse detoxification, withdrawal, guidance and counselling, and rehabilitation.

1. A new and already commissioned ward at Pantang Hospital shall be designated as Substance Abuse Unit.
2. Proposed mental health units in the regions should manage drug users by providing withdrawal and counselling services.
3. Similar units shall be provided in all the regions.

POLICY 5: TRAINING

Problem Statement

The mental health services have been experiencing severe manpower shortage.

Objective:

To train adequate number of staff for effective functioning of the mental health services.

Within the next 5 years, the following categories of staff be recruited or trained.

- a.
 - i. 10 psychiatrists
 - ii. 20 one-year diplomates in psychiatry
 - iii. 40 clinical psychologists
 - iv. 10 occupational therapists
 - v. 200 mental health nurses.
 - vi. 15 psychiatric social workers.

- b. Develop adequate training facilities for all grades of staff of the mental health services.

POLICY 6: CONDITIONS OF SERVICE IN THE MENTAL HEALTH SERVICES

Problem Statement:

There is no incentive for all grades of staff in the mental health service, considering the risks and hazards in their routine duties. There are instances in which doctors, nurses and other staff are physically assaulted.

Objective:

To motivate mental health workers in order to attract and retain them in the service.

Specific Recommendations:

1. 30% of salaries shall be paid to mental health workers as special allowance.
2. The provision of two incremental credits for staff with new additional professional qualification should be enforced.
3. Provision of transportation to and from the psychiatric hospitals or Units for the mental health workers who live away from these centres.

POLICY 7: MENTAL HEALTH AWARENESS

Problem Statement:

1. Ignorance, misconception and misinformation about mental patients in society and even among health workers are highly prevalent.
2. Lack of interest in and rejection of mentally ill and their families by their communities.

Objective:

To raise mental health awareness of the family and community at large.

- a. Plan, organise and implement mass health education on various aspects of mental health and substance abuse.
- b. Use drama, publication, radio, television and video programmes to educate and sensitise the community.

**POLICY 8: POSITION OF MENTAL HEALTH PERSONNEL IN THE
REGIONAL AND DISTRICTS HEALTH MANAGEMENT TEAMS
(RHMT/DHMT)**

Problem Statement:

1. Inadequate recognition of mental health personnel at the regional and district levels.

Objective:

1. Formalize the position of Mental Health Personnel as a member of
of
the RHMT & DHMT.
2. Educate the RHMT & DHMT nurses on mental health issues through workshops and seminars.

**POLICY 9: TRANSPORTATION FOR COMMUNITY MENTAL HEALTH
SERVICES**

Problem Statement:

Lack of transportation for community mental health programmes.

Objective:

To provide means of transport ,namely three (3) motor bicycles and five (5) push bicycles for each district for Community Mental Health so as to achieve wider coverage of mental health programmes.

- a. Ministry of Health to provide districts with adequate transport for mental health services in the community.

- b. **Coordinate with other departments in the districts (DHMT, District Assembly and others) on the use of vehicles as and when needed for Mental Health programmes.**

**POLICY 10: QUARTERLY AND ANNUAL REPORTS ON MENTAL
HEALTH ACTIVITIES AT REGIONAL AND DISTRICT
LEVELS**

Problem Statement:

Information on mental health activities does not reach the Director General of Health Services at the Ministry of Health Headquarters.

Objective:

To provide quarterly and annual report on mental health activities in the districts and regions.

- 1. Regional Director of Health Services in each region shall send the Annual reports on mental health activities in the districts and the regions to the Director General of Health Services.**
- 2. Quarterly and annual reports from the districts shall be sent to the Regional Directors of Health Services with copies to the Chief Psychiatrist, Director of Policy, Planning, Monitoring and Evaluation and National Coordinator of Community Mental Health Nursing to facilitate national planning.**

3. To ensure effective dissemination of information to relevant quarters.
4. The mental health secretariat will collect all relevant information and present them annually to the Director General of Health Services.

POLICY 11: ANNUAL MENTAL HEALTH SERVICES REVIEW AND PLANNING MEETINGS

The Chief Psychiatrist shall organise annual Mental Health Services Review and Planning meetings for mental health personnel of Ministry Of Health.

POLICY 12: QUALIFICATION OF COMMUNITY MENTAL HEALTH UNIT WORKERS AT VARIOUS LEVELS

a. **REGIONAL LEVEL:**

The Head Nurse shall have SRN/RMN qualification with a minimum of one-year post RMN working experience and three months Community Mental Health Nursing orientation.

b. **DISTRICT LEVEL:**

The Head Nurse shall have SRN/RMN qualifications with a minimum of one-year post RMN working experience and three months Community Mental Health Nursing orientation.

**POLICY 13: REHABILITATION OF THE MENTALLY ILL IN THE
COMMUNITY**

Problem Statement:

1. There is no well-defined national policy on the role of Ministry of Health for rehabilitation of mentally ill in the community.
2. Lack of facilities for rehabilitation of mentally ill in the community.

Objectives:

1. To integrate mentally ill into the community.
2. To provide rehabilitation facilities for the mentally ill in the community.
 - a. Provision of Rehabilitation Centres within the Communities.
 - Half way homes } Social Welfare together with M.O.H.
 - Day Care centres } Social Welfare together with M.O.H.
 - Hostels } Social Welfare together with M.O.H.
 - b. Collaborate programmes and activities on Rehabilitation with other agencies e.g. Department of Social Welfare, Ministry of Agriculture
Ministry of Education, Mental Health Association and Non-Governmental organizations.

POLICY 14: TREATMENT OF MENTAL PATIENT

1. Treatment of the mentally ill shall be free.

ACRONYMS

BMCS- Budget Management Centers

CPNS - Community Psychiatric Nurses

DHMT- District Management Team

HQ - Headquarters

HIV - Human Immune deficiency Virus

IDU - Injection Drug Use

NGO - Non-Governmental Organization

NRC - National Redemption Council

MOH – Ministry Of Health

PHC - Primary Health Care

PNDC – Provisional National Defence Council

PNO - Principal Nursing Officer

RHMT – Regional Health Management Team

WHO – World Health Organization