

# Research Report

## **BasicNeeds** *BasicRights*

### **Practice of Community Mental Health: Seeking Reliability and Quality assurance in Low and Middle Income Countries.**

June 2008

Yaro, Badimak Peter  
*Country Programme Manager*

Truelove Antwi-Bekoe  
*Policy Research Project Officer*

Evans Oheneba Mensah  
*Research Officer*

Alando Bernard  
*Doc. and Learning Associate*

## **EXECUTIVE SUMMARY**

Existing systems for the delivery of health care, including mental health care, have been noted by many writers as inadequate in meeting the needs of most of the world's populations due to the centralised, hospital based nature of such systems.

With a successful approach of a community based mental health and development model, integration of treatment services to Primary Health Care has demonstrated multiplier effective healthcare delivery that incorporates, not isolate, mental health care. The Community Mental Health Module of the BasicNeeds Mental Health and Development Model effectively ensured this paradigm is ideal. Working together with partners such as the Ghana Health Service and a number of Community Based Development Organizations, BasicNeeds has helped to ensure that long-term and easy access to community-based mental health services is available to people having mental illness and epilepsy in Ghana.

Quarterly specialist psychiatrist community based outreach services, organised by BasicNeeds in collaboration with the Ghana Health Service, have gone a long way to help poor people with mental illness and epilepsy, who otherwise would have found it difficult to access these services, to benefit from regular treatment services, including reviews and counselling services.

Community Psychiatric Nurses (CPNs) also hold follow-up outreach clinics outside the hospital premises in the communities to ensure that treatment services are not interrupted awaiting the next specialist visit. This has significantly improved recovery rates for mentally ill people and people suffering from epilepsy.

With few CPNs, BasicNeeds has supported community volunteers to undertake regular home visits to mentally ill people and people with epilepsy to interact with them and their primary carers and find out and report on their progress or otherwise. These volunteers have been trained to support other community workers and CPNs in their jobs, thereby releasing the latter from their busy schedules.

Feedback from people suffering from mental illness and epilepsy about the adequacy of mental health services revealed that overall, they are satisfied with the services they receive in spite of the side effects they experience when they take the medications and the contention that some of the psychotropic medicines have lost its efficacy.

Despite the challenges of inadequate mental health professionals, inadequate and irregular supply of psychotropic medicines, poor (mental) health infrastructure and the rest, community based mental health services are improving as a result of the collaboration BasicNeeds Ghana has received so far from the health authorities and partners.

Training of general health nurses and general practitioners in the early recognition and management of mental illness, improving availability, access to and use of basic psychotropic medicines, adequate provision and equitable distribution of funds for community mental health services, improving research and evaluation of mental health policy and services, encouraging the involvement of families and communities in providing support and monitoring mental health service provision and supporting stronger community and national level user groups of people with mental illness and epilepsy to be involved in monitoring quality of mental health services and general health care services provided to mentally ill people have been noted as some of the ways to achieve good quality community mental health services.

## TABLE OF CONTENT

|  |    |
|--|----|
| EXECUTIVE SUMMARY .....  | 2  |
| TABLE OF CONTENT .....   | 3  |
| ABBREVIATIONS & ACRONYMS .....                                 | 4  |
| 1.0 INTRODUCTION .....   | 5  |
| 2.0 METHODOLOGY .....  | 6  |
| 2.1 Data Sources .....   | 6  |
| 2.2 Process of Data Collection .....                           | 6  |
| 2.3 Limitations .....  | 7  |
| 3.0 COMMUNITY MENTAL HEALTH.....                               | 8  |
| 3.1 Location of Community Mental Health Services.....          | 8  |
| 3.2 Identification of Mentally ill People .....                | 8  |
| 3.3 Mental Health/Outreach Clinic.....                         | 9  |
| 3.3.1 Documentation .....                                      | 10 |
| 3.4 Follow-up.....   | 10 |
| 3.4.1 Follow-up Outreach Clinics.....                          | 10 |
| 3.4.2 Follow-up in Psychiatric Hospitals .....                 | 11 |
| 3.4.3 Follow-up in Communities/Homes.....                      | 11 |
| 3.5 Resources for Community Mental Health.....                 | 11 |
| 3.5.1 Psychotropic Medicines .....                             | 12 |
| 3.5.2 Human Resource.....                                      | 12 |
| 3.5.3 Transport Facilities.....                                | 12 |
| 3.5.4 Information, Education and Communication Materials ..... | 12 |
| 3.5.5 Motivation for Community Mental Health Workers.....      | 12 |
| 3.6 User perspectives on Community Mental Health Services..... | 13 |
| 4.0 QUALITY COMMUNITY MENTAL HEALTH SERVICES.....              | 15 |
| 4.1 Challenges .....   | 15 |
| 5.0 RECOMMENDATIONS .....                                      | 17 |

## **ABBREVIATIONS & ACRONYMS**

|      |                              |
|------|------------------------------|
| BN   | BasicNeeds                   |
| CPN  | Community Psychiatric Nurse  |
| CPNs | Community Psychiatric Nurses |
| GHS  | Ghana Health Service         |
| WHO  | World Health Organisation    |

## **1.0 INTRODUCTION**

Existing systems for the delivery of health care, including mental health care, have been noted by many writers as inadequate in meeting the needs of most of the world's populations due to the centralised, hospital based nature of such systems.

The fundamental role of primary care for the entire health system in any country was clearly stated in the Alma-Ata Declaration, 1978 (Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978). This emphasizes that mental health should be a component of primary health care. The World Health Organisation (WHO) in 2001 also strongly advocated for a focus on community mental health, and de-emphasizing institutionalisation of mental health care.

BasicNeeds (BN) works to bring about a lasting change in the lives of mentally ill people around the world. With a successful approach of a community based mental health and development model, integration of treatment services to Primary Health Care has demonstrated multiplier effective healthcare delivery that incorporates, not isolate, mental health care. The Community Mental Health Module of the BasicNeeds Mental Health and Development Model effectively ensured this paradigm is ideal. Working together with partners such as the Ghana Health Service and a number of Community Based Development Organizations, BasicNeeds has helped to ensure that long-term and easy access to community-based mental health services is available to people having mental illness and epilepsy in Ghana. Since 2002, BasicNeeds Ghana has now supported 16,024 of the 16691 mentally ill people and people with epilepsy to gain access to regular community based treatment services in its operational areas namely, Greater Accra, Northern, Upper East, Upper and West Regions with about 14,208 of them experiencing reduced symptoms. This has been made possible with funds received from Comic Relief, UK, The UK Department for International Development (DFID), the European Commission (EC) and several UK Charity Trusts and Foundations for the implementation of the Community Mental Health module which is an integral part of the overall BasicNeeds Mental Health and Development Model.

Despite the challenges of inadequate mental health professionals, inadequate and irregular supply of psychotropic medicines, poor (mental) health infrastructure and the rest, community based mental health services are improving as a result of the collaboration BasicNeeds Ghana has received so far from the health authorities and partners.

The remaining chapters of the report explain how data was gathered for this study and also seek to give vivid evidence and experiences of BasicNeeds' community mental health approach, challenges faced in ensuring that mental health services are community based and recommendations for quality and reliable community based mental health services.

## **2.0 METHODOLOGY**

Information for this study has been largely documented evidence already available since BN started its work. However, case studies were used to provide primary data. This method leads to understanding of the case and provides the basis for the application of ideas or evidence. The selected areas were Upper East Region, precisely Bolgatanga Municipal area, Kassena-Nankana district and Okaikoi sub-metropolitan area in the Greater Accra Region.

### **2.1 Data Sources**

Three focus group discussions were held in each of the three places mentioned above with mentally ill people and people with epilepsy and their carers who have been accessing regular community mental health services. A question guide was used to aid in the discussion. In total, 68 people participated in the discussion. This comprised 49 people with mental illness and epilepsy (38 females; 11 males) and 19 carers (13 females; 6 males).

Key informants such as the Deputy Director of Nursing Services, Psychiatry in Upper East Region and three other CPNs, one in the Kassena-Nankana district and two in Okaikoi polyclinic, were interviewed with the use of a questionnaire.

Observations were also made at two outreach clinics held in Navrongo and Bolga.

Existing documents such as process documents from consultation and participatory review meetings with mentally ill people, reports of outreach clinics and follow-up outreach clinics from Psychiatrists and CPNs respectively were reviewed to get related literature on processes and views about the quality of community mental health services.

The combination of these methods as is typical of case studies enhanced triangulation, leading to accuracy, high degree of reliability and replicability of methods.

### **2.2 Process of Data Collection**

#### **Focus Group Discussion**

In Northern Ghana, the focus group discussion was planned to coincide with the specialist outreach clinics in the districts. Volunteers and partner field staff went round to inform mentally ill people, people having epilepsy and their carers for outreach clinic. Alongside this, they notified them that there would be a short discussion with them after they had been attended to by the psychiatrist. In Bolgatanga, twenty people with mental illness and epilepsy and carers were selected randomly for the discussion. In Navrongo, there were some rain showers, so that opportunity was used to get the first 15 people who had finished consulting with the psychiatrist. By the middle of the discussion, the number had risen to 20.

In Accra, the Research Officer discussed with two community volunteers in Okaikoi about the research and the need for focus group discussions. A date to hold this discussion was agreed upon with them. The volunteers then informed and mobilised mentally ill people and people with epilepsy who would be involved. Twenty eight people with mental illness and epilepsy and ten carers participated in the discussion.

For ethical reasons, permission was sought from the mentally ill people and their carers to document the discussions and also to take photographs.

**Interviews**

Phone calls were made to the CPNs informing and requesting for their time for discussions on an agreed date. In the case of Northern Ghana, the discussions with the CPNs were held on the outreach clinic day.

**Observations**

Permission was sought from the psychiatrist for the Policy and Research Officer to stay in the consulting room to observe and document the process.

**Analysis**

Analysis was done by reviewing related documents, process documents of focus group discussions, interview/meeting notes and observation documented.

**Report Writing**

The data gathered was sorted, categorized and analysed into themes used in data collected as per the terms of reference for the study.

**2.3 Limitations**

Planning this study to coincide with the outreach clinic posed a challenge in the sense that because mentally ill people had stayed in long queues waiting to be consulted, it was difficult to keep them focussed as most of them were in a hurry to go back home or attend to their work/businesses.

In Navrongo, there a downpour which was a good opportunity to keep them discussing. Unfortunately, as soon as the rain stopped immediately the rains stopped, most women, majority of the participants, pressed for an end to the discussions to enable them go to the market to sell their wares in the market since it was a market day.

### 3.0 COMMUNITY MENTAL HEALTH

#### 3.1 Location of Community Mental Health Services

Community Psychiatric Units are situated within the district hospitals in Northern Ghana and in the polyclinics in Accra. This is mainly where community mental health services such as diagnosis and medications are provided during outreach clinics and other reviews of the people with mental illness and epilepsy. Where there is no Community Psychiatric Unit, community mental health services are offered at a designated room within the district hospital. In the sub-districts, such services are provided at the health centre. According to the Regional Coordinator in charge of community psychiatry in Upper East Region, Community Psychiatric Nurses (CPNs) in the Region also provided community mental health services right in the homes of mentally ill people. Upon receiving information about an aggressive patient, we ask for directions to their homes and counsel them or give treatment.

#### 3.2 Identification of Mentally ill People

There are multiple ways of identifying new cases of mentally ill people including those suffering from epilepsy.

1. The CPNs indicated that they have the traditional responsibility to go into communities to find new people with mental disorders but this is done on a limited scale because of few CPNs and inadequate resources.

2. According to Mr. Sobsar, CPN for Kassena/Nankana District, through BasicNeeds, he has been able to train some auxiliary nurses and general health nurses in basic psychiatry. As a result, rather than send them away right at the level of Out Patient Department (OPD) they are now sensitive to the other psychological problems patients present and able to cope with them in terms of treatment, especially for the epileptics. In Accra, the situation is not different with that explained by Mr. Sobsar. CPNs interviewed explained that as a result of the training in basic psychiatry organised by BasicNeeds for the general nurses, they are able to detect suspicious behaviours including other signs and symptoms of mental illness and refer them to the CPNs.

In a similar vein, other referrals are made by community volunteers, BasicNeeds implementation partners' field staff, members of the Upper East Regional Alliance and Community Health Workers who have all been trained in basic psychiatry with the support of BasicNeeds.



3. Usually, announcements are made about specialist outreach clinics in the community using churches, mosques and the town-crier who beats a gong-gong (a type of drum) round the village/community to draw attention and give the announcement. The mentally ill and those suffering from epilepsy are also informed by their relatives about the specialist clinics to take place. The message is also passed on by community volunteers who visit the homes of mentally ill people they know in the community to inform their families to attend the clinic with their relations having mental illness and/or epilepsy. New cases of mentally ill people are also identified when people with mental illness and epilepsy come for such outreach services which is held quarterly in

all 38 districts of the three northern regions of Ghana the four sub-metropolitan areas of the Accra Metropolis in Greater Accra region. This specialist outreach clinics are being facilitated by BasicNeeds in collaboration with the Regional, Sub-Metropolitan and District Directorates of the Ghana Health Service of the areas BasicNeeds works in.

4. CPNs who were interviewed in Accra made it known that sometimes they identify new mentally ill people by visiting the wards of the Psychiatric Hospitals to interact with them. Through the interaction, the nurse is provided important information that would enable him or her trace the home of the mentally ill person. As to what happens next, Ms Deborah Adefowofo, CPN in Okaikoi had this to say, *"We then prepare the home of the mentally ill person. We do this by preparing the relatives' minds. This is achieved by way of educating or explaining the condition of the person with mental disorder to his/her relatives. This process is important to help the relatives to understand the condition of the sick, the signs, symptoms and treatment regimen. When the patient is discharged he or she is then referred to the polyclinic for treatment to continue."*
5. Finally, people suffering from mental illness and epilepsy and their carers who receive mental health services inform others they find with signs and symptoms of the same ill-health and also testify to other people including those they think might be having similar problems about the services and they in turn call in at the mental health service points for advice.

### **3.3 Mental Health/Outreach Clinic**

The Ghana Health Service, specifically the Community Psychiatric Unit, is the main collaborator for community mental health services. The process of a community mental health outreach begins with discussions with the Psychiatrists concerned on dates for the outreach which is then communicated to the Coordinators in charge of Community.

Psychiatric Nurses in the various regions where the outreach clinics are to be held agree on dates and other logistical arrangements. Letters are sent to the Regional, and also sometimes to the Sub-Metropolitan and District, Directors of Health Services with copies to the coordinators, Community Psychiatric Nurses and focal persons in charge of Community Mental Health officially notifying them of the outreach. The CPN or focal person with the support of volunteers under his/her supervision mobilises mentally ill people and their carers for the outreach clinic. People with mental disorders and epilepsy come from several communities under the district where the outreach clinic is being held to a designated location. This is usually in the district capital. Where psychiatric units exist, outreach clinics are held there, otherwise they are held in a designated room within the hospital premises or a health centre.

The psychiatrist takes the history of mental illness or epilepsy of the person concerned and this is mostly told by the mentally ill person or the person with epilepsy with contributions and corroborations from the carer or the ill person as the case may be. The diagnosis is arrived at from these interactions and the treatment and medicines prescribed them provided. In addition to the medicines prescribed the individual and the carer are also counselled; which ever the psychiatrist deems appropriate. Medicines are given at no cost to the person suffering from mental illness or epilepsy. In the Northern Ghana Programme area, if the person is an coming for a review, the medication is usually given for a thirty-day period by which time the mentally ill person is expected to return to the clinic for subsequent review. On the other hand, if the person is coming for treatment for the first time, the medication is given for two weeks so that he or she returns to the CPN for review. When the situation (for both new and review cases) is beyond the abilities of the CPN, he refers the new patient to the Accra Psychiatric Hospital. In the event of any reaction to the prescribed medicine, the person can return to the clinic earlier than the given period for review.

CPNs review old cases and advise them after listening to how they are progressing on the treatment. The CPN either give same, reduced or higher dosages or even change the medicines depending on how the mentally ill person is responding to the treatment given. Ideally, a Community Psychiatric Nurse is not supposed to diagnose and prescribe medicines but because there is no Psychiatrist in the northern part of Ghana, they are forced to perform such functions when a new mentally ill person or person with epilepsy is identified or brought to the Psychiatric Unit. The mentally ill person continues with the treatment until a specialist outreach clinic is held where such a person will present the history to the Psychiatrist for further counseling or standardized treatment or is simply referred to Accra to see a Psychiatrist if the CPN find condition to be beyond him/her. Usually, it takes about two months before a new patient sees a psychiatrist because outreach clinics are held quarterly.

Other functions performed at the community by the CPNs are periodic mental health talks at the hospitals, schools and communities to sensitise the general public about the causes, symptoms and prevention of mental illnesses. CPNs also counsel people with mental disorders and epilepsy during review clinics. Sometimes it is done like a general talk before the start of consultation. When a patient needs counseling instead of medicines, it is done in confidence at the consulting room. Volunteers also do some counseling when they visit the homes of people with mental disorders and epilepsy. When a volunteer finds out that a person is not being well care, he or she advises the carer (s) of the person with mental disorders and epilepsy on how to care for them and how their care contributes to their faster recuperation.

In districts where there are no CPNs, BasicNeeds has supported in training in basic psychiatry to general health nurses, as well as selected para-medical staff connected health service delivery (e.g. Community Health Service and Planning Coordinators) known as focal persons to be responsible for mental health services in such areas by giving some basic mental health services to mentally ill people. This has significantly improved recovery rates for mentally ill people and people suffering from epilepsy.

### **3.3.1 Documentation**

In all these services provided to mentally ill people, CPNs, Psychiatrists, Health Workers and sometimes volunteers, BasicNeeds partner field staff and staff of BasicNeeds record the personal and clinical data such as names, sex, ages, contact address and diagnosis of people having mental illness and epilepsy and whether the person is coming for treatment for the first time or for a review. The names and ages of their carers (if any) are also documented. Hard copies of such records, in addition to the psychiatrist's report, are given to the regional and district health directorate where the outreach is held whilst both the hard and soft copies of these are kept in BN office. The individual medical/clinical files of each of the people seen are kept at the Community Psychiatric Unit.

Overall, this data form part of BN's research and is used specifically in annual research report, Annual Programme Impact Report, and internal monthly bulletin known as Programme Management System (PMS). They are also very useful as evidence during BN's policy meetings/engagement.

### **3.4 Follow-up**

According to CPNs, follow-ups are done at three levels; outreach clinics, visits made to the psychiatric hospitals and undertaking home visits.

#### **3.4.1 Follow-up Outreach Clinics**

In Northern Ghana, CPNs conduct follow-up outreach services at the sub-district level thereby sending treatment closer to the people in their communities. The processes and protocols followed are the same as what is done during the specialist outreach clinics. When the treatment for mentally ill people

have been standardised by the psychiatrist, medicines are subsequently administered by CPNs when mentally ill people go for review. This is done by referring to the clinical records of patients.

### **3.4.2 Follow-up in Psychiatric Hospitals**

In Accra, CPNs said they follow up to the hospital to trace the client who had earlier on been referred to the Psychiatric Hospital. The idea of the 'hospital follow-up' is to ensure that the patient identified at his/her home had, upon referral, actually reported to hospital to access treatment. Knowing the name and other particulars of the patient identified at the community, the CPN visits the records section of the hospital to verify information about the patient. In case the checks at the records section show that the patient had reported for treatment and is on admission, the CPN then visits the ward to ask about the condition of the patient. In the case where the person has failed to report, CPNs visit his or her home to find out why such a person has not showed up.

### **3.4.3 Follow-up in Communities/Homes**

The findings revealed that home visits are done on a limited scale because of inadequate transportation as well as inadequate staff coupled with the rough terrain of some communities. Despite these challenges, CPNs interviewed explained that home visits are undertaken when there is a difficult case to deal with; for instance when the person is very aggressive and uncompromising. In addition, CPNs mentioned that when they notice that a mentally ill person has defaulted in coming for treatment they follow-up to their homes to find out what might be the reason.

In addition to this, in Accra, the CPNs visit the psychiatry hospital and go through the admission and discharge records at the ward. Where appropriate contact details (telephone and or house address) have been indicated, they trace the home and visit the mentally ill person who has been discharged.

BN also supports community volunteers to conduct follow-ups to the homes of the mentally ill to find out if mentally ill people and their carers are complying with the prescriptions given. This is to ensure that the medicines are not taken in excess of, or less than the dosage. Volunteers visit the homes of mentally ill people and report on monthly basis the current health status and the livelihood activities of mentally ill people. They also report on any other issue they think is worth noting. For instance whether the mentally ill person has gone back to school or is now able to participate in other social activities like church, mosque, funerals, naming ceremonies, any side effects they may be experiencing from the medications they take or issues of relapse and defaulting in going for drugs, etc. The name, age, sex, mental ill-health or type of epilepsy experienced, general health status and livelihood activity the mentally ill person is engaged in are also documented.

In all these, CPNs observed that an important element in any effective follow-up is establishing rapport with the mentally ill person and other family members. This, according to them is done by introducing oneself and explaining the purpose of the visit. As part of the follow-up, the CPN or community volunteer inquires whether the medications are taken according to what has been prescribed. This is verified by inspecting the medicines. One other essential activity that sometimes takes place during follow-ups is review of the mentally ill person. The visit also offers an opportunity for mentally ill people and people suffering from epilepsy to receive information on dates for review at the psychiatric unit or specialist outreach clinics.

## **3.5 Resources for Community Mental Health**

Allocation of resources is critical to the realization of a viable community mental health system. Generally, mental health services are widely under-funded, especially in developing countries. WHO (2001a) notes that nearly 28% of countries do not have a separate budget for mental health. Of the countries with separate mental health budgets, 37% spend less than 1% of their total health budgets on mental health. Less than 1% of total health budgets is spent on mental health by 62% of

developing countries and 16% of developed countries. The Mental Health Atlas (2005) indicated that Ghana spends 0.5% of the total health budget on mental health. Thus there is a significant discrepancy between the burden of mental disorders and the resources devoted to mental health services.

When there is an outreach clinic, the GHS contributes by providing office space, personnel, vehicle, medicines, accommodation and meals to the visiting psychiatrist.

CPNs mentioned a number of resources that are needed for providing effective community mental health services. These are:

### **3.5.1 Psychotropic Medicines**

The most important thing in delivering community mental health services are psychotropic medicines and anti-convulsants. These have to be supplied regularly so that they are always available for those who need them.

### **3.5.2 Human Resource**

The CPNs expressed the opinion that, perhaps the second most important resource for an effective mental health delivery is the human resource- Psychiatrists; Community Psychiatric Nurses; Volunteers, general health workers (General Practitioners, Nurses) being involved in mental health care delivery service etc. They mentioned that the small number of Psychiatrists in Ghana has made it impossible to have psychiatric services reach every one who required such services. In Upper East Region, Peter Akagwire disclosed that even though the Region has the highest number of CPNs in Northern Ghana, it is still woefully inadequate considering that 4 districts out of 9 do not have CPNs and even in districts where there are, the community psychiatric unit is manned by only one CPN. In the event of that person being sick or incapacitated, there will be no one to perform such functions even when medicines are available.

### **3.5.3 Transport Facilities**

Another resource required for the provision of community mental health services is transport. The CPNs interviewed complained that they cover a large geographical area and in most of the communities, the houses are far apart. The situation is worsened in the hard to reach areas especially during rainy season where significant parts of the north-western parts of Northern Region and similar areas are inaccessible. This calls for vehicles that can be used in such difficult terrains.

### **3.5.4 Information, Education and Communication Materials**

The CPNs also underlined the importance of communication equipment and related materials. They mentioned that during an emergency, telephone communication can be relied upon to ensure that a nurse or doctor is easily contacted to attend to a critical condition at a mental health facility. Public Education Materials were also mentioned as resources needed to educate community members on various mental health issues. Such public education materials include mental health cards; pictures; leaflets; brochures; handouts, as well as equipment including television and video and digital cameras; etc.

### **3.5.5 Motivation for Community Mental Health Workers**

CPNs noted that the pivot around which community mental health revolves is finance. They were of the view that whilst money is needed, motivation for CPNs in terms of involving them in the management of health services and awards or promotion for hard working staff will go a long way to create the needed incentive for effective community mental health services.

### 3.6 User perspectives on Community Mental Health Services

Feedback from people suffering from mental illness and epilepsy about the adequacy of mental health services revealed that overall, they are satisfied with the services they receive. About 27 out of 49 mentally ill people and those suffering from epilepsy said that in the past, they had oscillated between traditional healers and spiritual camps and all yielded fruitless outcomes and that even though there are some challenges faced in seeking community mental health services, the services the CPNs and psychiatrists provide are of good quality. From the perspective of mentally ill people and their carers, good quality community mental health services means that the services are able to help reduce their symptoms and improve their overall quality of life. Some of the responses have been summarised in box 1 below.

#### BOX 1

- *There is no problem with the services. The nurses at the unit are very nice to us. They are always available to serve us.*
- *We are happy about the psychiatrist visits. We hope this continuous until we are fully recovered.*
- *The medicines are good because hitherto, I could not sleep well but now I do.*
- *The medicine has changed my condition because I used to experience frequent seizures but now it has reduced to about once in two months.*
- *The search for healing of my epilepsy took me first to a traditional healer at Ofankor near Accra. However, the illness persisted. I then sought solace in a spiritual camp. I did not get well at this camp either. Eventually, I had treatment at the Accra Pschiatric Hospital'.*

#### 3.6.1 Contention that some of the Psychotropic drugs have lost their efficacy

Despite the above commendation, some people having mental illness and epilepsy contended that some of the drugs given them at the clinic and hospitals are no more effective in stabilizing their condition. They particularly mentioned that phenobarb tablets do no longer manage their epileptic conditions to a satisfactory degree. There is also a growing concern of fake drugs undermining the efficacy/potency of some of the psychotropic medicines.

#### 3.6.2 Side Effects

Others also observed that they experience some side effects such as over sleeping, stiffness, dizziness, etc when they take the medicines. However, what was of much concern was the fact that the medicines make eat more than they would have and this drains their resources.

#### 3.6.3 Long Queues

Mentally ill people remarked that though the specialist outreach clinic was a good thing, they were worried about the long queues that they have to be in to see the Psychiatrist. *"We are not usually comfortable with the long queues coupled with the selection of who sees the psychiatrist first. Some of us were here since 2am but it is only now 1.45pm (13.45GMT) that we have been able to see him."*

#### 3.6.4 Rotation of Psychiatrists Who Attend Quarterly Outreach Clinics

For most mentally ill people in Accra, the arrangement under which the same psychiatrist does not visit the outreach clinic in subsequent periods was problematic. Some mentally ill people observed that each quarter a different Psychiatrist attended an outreach clinic, he or she advised patients to disregard drugs prescribed by another psychiatrist. A mentally ill person said when the advice to discontinue with the medication was adhered to, he relapsed.

It was observed in Northern Ghana during the outreach clinic in Upper East that, there were instances where the psychiatrist changed the medicines which mentally ill people were previously taking which had been prescribed by a different psychiatrist. When asked about the reason for the change of medicine, the psychiatrist explained that generally apart from side effects the person may be experiencing that calls for a change of medicine, sometimes the availability of the medicine and

affordability also plays a role. He noted that some of the medicines that are not available and so prescribed for mentally ill people to buy from outside are not bought because of its high cost. In such instances he explained that it is best to put the person on the available medicine to ease the financial burden of the patient or the carer.

It was also observed that the frequent changes in the psychiatrists caused delays in the consultation process as sometimes the psychiatrist may either have to read the history of the illness from available records or let the carer or mentally ill person repeat such instances. This may be a contributory factor for the long delays in queues apart from the huge numbers that turn up.

### **3.6.5 Non Availability of Prescribed medicines**

Twenty (20) mentally ill people said they did not always get medicines prescribed to them by the Psychiatrists from the pharmacies located at the polyclinics. For that reason they had no alternative but to resort to the open market where they are forced to buy these drugs at exorbitant prices. The high prices for drugs make it impossible for them to acquire the drugs in the required quantities as prescribed.

### **3.6.6 Long Distance/ Mounting Transportation Costs to the Polyclinics**

Mentally ill people who come from Dedeiman in Accra and Nayagnia in Navrongo complained that they cover more than 50 kilometres and 15 kilometers respectively in order to get to the polyclinic at Kaneshie and psychiatric unit of the Navrongo Hospital in Navrongo. In terms of cost, each person in Dedeiman pays Twelve Cedis to get to the Polyclinic. For Northern Ghana (Navrongo), they have to walk with few people riding bicycles. Even then, carers were of the view that they were always worried leaving their epileptics to ride bicycles on their own as they could have seizures in the course of riding.

## 4.0 QUALITY COMMUNITY MENTAL HEALTH SERVICES

In discussions with CPNs and mentally ill people and their carers, the following issues were mentioned as key ingredients for good quality community mental health services:

- Training of general health nurses and general practitioners in the early recognition and management of mental illness so that institutionalization of mental health services can be reduced.
- Increase in the number of community psychiatric nurses.
- Refresher trainings on mental health care for CPNs.
- Equipping CPNs with the requisite knowledge and skills as well as authority to diagnose and prescribe psychotropic medicines at the community level.
- Supporting psychiatrists to provide regular assistance and to monitor the activities of CPNs.
- Improving availability, access to and use of basic psychotropic medicines.
- Effective referral linkages so that mentally ill people can be conveniently traced if they are discharged from psychiatric hospitals. This is absolutely necessary especially in instances where such people are discharged from Accra back to their homes in the north.
- Adequate provision and equitable distribution of funds for community mental health services.
- Proper coordination of mental health activities
- Improvement in mental health information systems for proper documentation.
- Improving research and evaluation of mental health policy and services.
- Encouraging the involvement of families and communities in providing support and monitoring mental health service provision.
- Supporting stronger community and national level user groups of people with mental illness and epilepsy to be involved in monitoring quality of mental health services and general health care services provided to mentally ill people.
- An informed public with a positive attitude towards mental health and people with mental illness and or epilepsy

### 4.1 Challenges

CPNs pointed out that current community mental health services are not able to meet the demand placed upon them because of insufficient numbers of mental health personnel. The deprived areas are worst affected as there are no psychiatric nurses for ongoing care. At best the general health nurses are only able to prescribe anti-convulsants to those suffering from epilepsy.

Current inadequate staffing levels mean CPNs are over-stretched and cannot provide effective community mental health services that mentally ill people need and when community psychiatric nurses go off sick or are on leave, services for mentally ill people are withdrawn.

CPNs also highlighted irregular supply of psychotropic medicines. Carbamazepine for instance was noted to be out of stock in both Accra and Northern Ghana for about two years now. This shortage means that appropriate medicines for some conditions will sometimes have to be prescribed for mentally ill people. Inconsistencies in the supply of psychotropic medicines have been confirmed by mentally ill people and their carers during focus group discussions. They stated that, they have insufficient funds to purchase from pharmacy shops. This situation is worsened for those who live in remote communities because they have to travel to the district capitals before they can get a chemical shop or Pharmacy.

CPNs mentioned that there are inadequate resources for

*"During rainy season, when we undertake follow-up outreach clinics or home visits, we sometimes get soaked when it rains and we lose vital information that should have been documented. The lack of computers to store information results in scattered documents especially for those of us who do not have a permanent consulting room of our own. Over here (referring to his office) when it rains and we are not around, all the files get soaked". Peter Akagwire*

community mental health. Peter Akagwire, Coordinator for community psychiatry in Upper East Region explained that, for instance because there is no vehicle it is difficult to send mentally ill people with severe problems to Accra or Cape coast where the psychiatry hospitals are located. The other challenge of not having a vehicle is the result of inability of CPNs to undertake follow-up visits especially to mentally ill people living in deprived communities with rough terrains.

CPNs are of the view that one major factor that has resulted in few mental health professionals and thereby hampering effective community psychiatric services is the lack of job and professional progression and unstructured training for CPNs. Apart from this, CPNs mentioned that there is no opportunity for progression as a CPN unlike their counterparts (general health nurses) who have clear lines which makes them rise through the ranks. Moreover, according to them, since most of them received their formal training in 1975, they have had no formal refresher courses on community psychiatry to upgrade their skills with regard to modern practices in mental health apart from the ones BasicNeeds organized for them. This, they lamented emotionally, results in low levels of motivation for existing and potential CPNs.

In addition, the persons with mental disorders and carers usually had high expectations of CPNs. Ms Agnes Sam, a Community Psychiatric Nurse said the following in reference to the demands made on them by carers and persons with mental disorders. *"When I visit the patients in their homes, it is a common feature for them to ask me for everything ranging from salt, bread, sugar and money to buy food. Often I feel touched by the situation I find them in and on several occasions, I had to part with the few Cedis I had on me. More distressing is that at times, they would link the request for food and money to taking the drugs given to them at the clinic. They tell me that the medicines make them hungry and drowsy and that if I do not give them money to buy food, they will stop taking the medication".*

## 5.0 RECOMMENDATIONS

WHO, (2001b) notes that effective community mental health services have many advantages. These include less stigma for mentally ill people as mental and behavioural disorders being seen and managed alongside physical health problems; improved screening and treatment especially for those who need long-term support.

Resources need to be available for a successful community-based mental health services. This includes staff (Psychiatrists, community psychiatric nurses and community volunteers), psychotropic medicines, space and money. To ensure effective, reliable and affordable community mental health services the following recommendation should be taken into consideration:

Health policies and plans should take into account community mental health issues and make it an area deserving priority instead of the current focus on mental hospitals. CPNs mentioned that government should demonstrate a commitment to mental health by designing programmes to make community psychiatry studies attractive. They were of the view that a special incentive package should be awarded to people who avail themselves for such training so that it will appeal to many people especially the youth.

Ghana Health Service should commit resources to training and giving refresher training to primary health care staff in psychiatry so that mentally ill people can be identified by all doctors and nurses and receive the correct treatment quickly and efficiently.

In a similar vein, CPNs should be provided with refresher training courses and if possible, their roles should be expanded to enable them diagnose and prescribe medicines for mentally ill people. In addition to this the Ghana Health Service should bridge the gap and ensure equity by posting a resident psychiatrist to each of the regional hospitals at least for a start to work in the three northern Regions.

District Assemblies can address community mental health needs by sponsoring people to study community psychiatry so that they are bonded to come back and practice in the communities. The Mental Health Medical Assistants programme to commence in Kintampo through the partnership of the Lancashire Health Trust and government is one good initiative by government that should address upgraded, more integrated health personnel working on mental health.

The lack of resources in the mental health sector is echoed in calls for more funding. There should be parity with physical illness when resources and funds are being allocated, keeping in mind the proportionate burden of mental illness. If this is not done, it may gradually make community mental health services redundant as Peter Akagwire remarked, "*The grave of Community Psychiatry is so deep that if nothing is done about it and it is buried, it cannot be resurrected.*" The Ghana Health Service has mandate for the provision of healthcare services including mental healthcare. Community-based outreach services should therefore receive funding from the health budget of the Ghana Health Service. BasicNeeds has demonstrated how these camps can be successful by contributing to the payment of the psychiatrist fees and supporting in the purchase of psychotropic medicines when these medicines are not available in the central medical stores at the time of the outreach.

CPNs should also be more assertive (through training, skills in management, lobbying and advocating for their sector) than they do now to be able to take advantage of what is due them.

For psychotropic medicines to be available at all times, the procurement division of the Ministry of Health should consider applying to suppliers of psychotropic medicines at not-for-profit world market

wholesale prices such as the International Dispensary Association, the Supply Division of the United Nations Children Fund. People with mental illness and epilepsy and their carers have also recommended that the Ministry of Health should procure modern and more effective drugs to replace what they consider to be old drugs still in use at the hospitals and polyclinics.

The Ministry of Health should develop a national plan to encourage research on effective community mental health services and mental health issues in general.

In order to overcome the difficulties CPNs and other mental health professionals' face in undertaking follow-up home visits, it is recommended that Government should support the mental health unit with vehicles especially ones that would enable them to effectively move into remote communities. In addition, existing directors should pool resources such as motor-bikes and vehicles from other health projects to support mental health services, at least as a localised action at the district/regional health directorate levels.

According to the Community psychiatric Nurses there is the need to build new and strong bridges of communication through regular interaction with the mentally ill people and carers. They believe that such close interaction would not only contribute to building confidence in the mentally ill person but would also make mental health officials better understand the clients they work with and thus offer better quality mental health services.

There have been suggestions made by mentally ill people and their carers for Ghana Health Service and BasicNeeds to collaborate and organise specialist outreach clinics every month instead of the current one that is done on a quarterly basis.

They also appealed to BasicNeeds to enlist more people that have become stabilised into their sustainable livelihood programme. Their reason was that once they or their carers are able to go back to work and acquire income, they will be able to purchase their medicines and also buy more food to eat as the medicines make them eat too much.

## **REFERENCES**

1. Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978
2. World Health Organization (2001a) Atlas: Mental health resources in the world. Geneva: World Health Organization.
3. World Health Organisation, (2001b) World health report 2001. Mental health: new understanding, new hope. Geneva: World Health Organization.
4. World Health Organisation, (2005) Mental Health Atlas. Geneva: World Health Organization.