Republic of The Gambia
Department of State for Health
& Social Welfare

THE GAMBIA MENTAL HEALTH POLICY 2007

March 2007

Republic of The Gambia

Department of State for Health

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FOREWORD

The formulation of an appropriate and carefully prioritized policy is a key element in achieving the implementation of an effective and sustainable mental health care system.

This ten year policy sets out the main directions the Gambia will take to provide effective treatment and care to the thousands of people suffering from mental and substance abuse disorders. An important emphasis is placed on providing mental health service integrated into the wider general health sector, and putting an end to stigma and discrimination towards people with mental disorders and promoting mental health more generally. The policy which should be read in conjunction with accompanying five year action plan is part of the overall development effort under way in the Gambia.

The Gambian Governments' Department of State for Health and Social Welfare and the National Mental Health Taskforces' Technical Committee have drafted the policy after an in-depth situational analysis and extensive consultation with many different stakeholders from the community. Thanks also go to WHO-Gambia, WHO-AFRO and WHO Geneva offices, who provided financial and technical assistance for its development. A list of all those who contributed to the development of this policy are attached as an annex 1.

Dr Tamsir Mbowe,
Secretary of State for Health and Social Welfare.

SIGNATURE

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List of Abbreviations

ACU	Adult Care Unit
BSS	Bridging and Support Services
CBO	Community Based Organizations
CCU	Child Care Unit
CLS	Central Laboratory Services
CHNs	Community Health Nurse
CMHN	Community Mental Health Nurse
CMHT	Community Mental Health Team
DHS	Director of Health Services
DHTs	Divisional Health Teams
DOSH	Department of State for Health
EDC	Environment and Disease Control
EPI	Expanded Program on Immunization
EU	Education Unit
DPS	Deputy Permanent Secretary
HRD	Human Resource Development
HEU	Health Education Unit
HMIS	Health Management and Information System
HSR	Health System Research
IMCI	Integrated Management of Childhood Illness
ISTU	In-service Training Unit
MH	Mental Health
MHS	Mental Health Services
NACP	National AIDS Control Program
NECP	National Eye Care
NGO	Non Governmental Organizations
NRC	National Rehabilitation Center
PHC	Primary Health Care
PNO	Principal Nursing Officer

RCH	Reproductive and Child Health
RVTH	Royal Victoria Teaching Hospital
SENs	Senior Enrolled Nurse
SRNs	Senior Registered Nurse
TB/LEP	Tuberculosis and Leprosy
TMP	Traditional Medicine Programme
TU	Training Unit
WHO	World Health Organization

Glossary

Mental Health Policy: an organized set of values, principles, objectives and areas for action to improve the mental health of a population.

Value: A cultural belief concerning a desirable mode of behaviour or end-state, which guides attitudes, judgements and comparisons.

Principle: A fundamental truth or doctrine on which rules of conduct are based.

Areas for action: Complementary aspects of a policy that are separated for the purpose of planning.

Primary prevention: is to alter conditions that precipitate mental disorders and behavioral problems.

Secondary prevention: is an early detection and limiting the negative consequences once a psychological problem has manifested itself.

Tertiary prevention: is to control the long-term effects of chronic mental health problems.

Mental Health: A state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life.

Mental Disorder: the existence of a clinically recognizable set of symptoms or behavior associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here”

Mental retardation: "Mental retardation is a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e. cognitive, language, motor and social abilities" (ICD-10 definition).

CHALLENGES FOR MENTAL HEALTH POLICY

The in-depth situational analysis (annex 2) and the broad consultation process led in the Gambia within/as part of the policy development process have revealed a number of challenges for the development and implementation of a realistic and progressive mental health policy at national level:

1) The "pervasive **negative attitudes and prejudices towards mental disorders**" within all sectors of society which adversely affect the resources provided to treat and care for people with mental disorders at all levels including within the family, community and at national level.

2) The **limited infrastructure** available for mental health treatment and care.

The Campama Psychiatric Unit is the only available inpatient facility for the mentally ill. The lack of facilities elsewhere in the country results in patients traveling long distances from their home to access treatment. Important social support networks for patients are therefore weakened during the patients stay in the hospital. Care at Campama is mainly custodial in nature with very few human and material resources to provide for psychotherapy, drug therapy, counseling and rehabilitative facilities. Poor facilities and lack of a therapeutic environment reinforces erroneous beliefs that mental disorders are due to punishment and recovery is unlikely.

3) Inadequacy **of human resources** for mental health.

The inadequacy of human resources available to deliver appropriate mental health care is a major challenge for the Gambia. Recruitment and training of health workers in mental health should be a central component of the policy and plan in order to be able to achieve the objectives. The inadequacy of specialized staff with sufficient skills to provide training to other health workers should also be addressed.

4) The **current economic context** associated with **urban migration** disrupting traditional family and social networks is a contributing factor to the increasing mental health problems.

5) The **limited financial resources** available.

It is essential for the Gambia to be able to secure a budget allocated to mental health and not to entirely rely on external sources of funding which are subject to large fluctuations over time.

6) **Primary Care:** Few primary care workers are currently available in The Gambia with the necessary competencies to provide mental health care to patients suffering from mental disorders (this includes assessment, diagnostic, intervention, management, and monitoring skills). Training and sensitisation of professionals in primary care is essential and must precede reform strategies to decentralise mental health care services. It is unclear at this time if professionals in primary care are supportive and committed to becoming active participants in the care of the mentally ill in communities.

MENTAL HEALTH POLICY

Vision

Attainment of equitable, accessible and cost-effective mental health care for people living in the Gambia through the provision of quality mental health care integrated into all levels of care, by skilled and motivated personnel, with the involvement of all stakeholders.

Guiding values and principles

VALUES	PRINCIPLES
1. Mental Health Indivisible from General Health	➔ Mental health care should be an integral part of the primary health care system. ➔ Mental health services should be integrated into "usual" health care services at all levels (primary, secondary and tertiary). Stand-alone mental health services should not be encouraged. All health care professionals should be trained to provide mental health care appropriate to their role in the health care system. ➔ Mental health services provided within the health sector should be appropriately linked to other sectors (such as social services, justice, housing, education).
2. Accessibility and Equity	➔ Government services should be free of charge and accessible to all people, regardless of their geographical location, economic status, gender, race or social condition, or physical or mental disability. ➔ Mental health services should have parity with general health services. ➔ People with mental disorders, including mental retardation should not be discriminated against on the basis of their mental status. ➔ Mental health services should be available across the life span and across all levels of severity and need. ➔ People with mental disorders may require unique services designed to address their needs because of the nature of the mental disorders (for example: social rehabilitation for those individuals whose mental illness significantly

	affects their ability to understand or appropriately act in social situations). ➔ People with mental disorders may require affirmative actions due to the longstanding and pervasive stigma held by the public, professionals and policy makers against the mentally ill. ➔ Services must be as close to the homes of patients as possible and favour outpatient care.
3. Human Rights	➔ People with mental disorders should enjoy full human rights, including the right to appropriate health care, education, shelter and employment, and the freedom from discrimination and abuse. ➔ Mental health treatment and care should promote and protect the autonomy and liberty of people with mental disorders. ➔ People with mental disorders have the right to be treated in the most effective least restrictive and least intrusive manner. ➔ People with mental disorders, due to their particular vulnerability to human rights violations, may require specific legal and quasi-legal frameworks and safeguards to ensure that their human rights are promoted and protected. ➔ Care delivered to people with mental disorders should be strictly confidential.
4. Quality Services and Management	➔ Services provided to people with mental disorders should reflect the highest standard possible according to the state of scientific knowledge and the resources available.
5. Decentralization	➔ Authority, resources and services should be devolved from the central level to primary and community levels, allowing for more participatory decision making. ➔ The provision of community care alternatives should be tried before inpatient care is taken.
6. Community Involvement and Participation	➔ Mental health care should be provided in the community whenever possible. ➔ People with mental disorders should participate in the

	design and implementation of mental health projects from which they will benefit. ➔ Families of people with mental disorders should be considered as partners in mental health care and therefore actively participate in it, being educated and trained. ➔ Individuals with mental disorders, families and communities should be participants in mental health education programs. ➔ Media will be engaged to promote awareness and the active participation of the community
7. Rehabilitation	➔ There should be equal employment opportunities for people who have or have had mental disorders compared with other medical conditions. ➔ Community Based Rehabilitation activities for people with mental disorders should be encouraged in order to reduce their disability and improve their quality of life.
8. Protection of Vulnerable People	➔ The mental health needs and rights of vulnerable groups should be upheld, including the disabled, women, children, youth and adolescents and the elderly.
9. Cultural Sensitivity	➔ Activities promoting mental health should be designed with particular attention to cultural values of communities. ➔ Traditional healers should be involved in the prevention, detection and care of people with mental disorders, in collaboration with formal mental health care system.
10. Evidence-Based Care	➔ Scientifically validated evidence is the primary source of information used to inform decision making for services and interventions. • ➔ When scientifically validated evidence is not available, commonly accepted "best practices" may be utilized. ➔ Ongoing validation of services and interventions should be implemented and used to refine services and interventions and to inform resource allocations.

Objectives

In keeping with the vision, values and principles expressed above, the following objectives shall be realised:

i. To provide equitable access to quality mental health care to all people in the Gambia with mental and substance use disorders including vulnerable populations (i.e., children, women, the aged, migrants and refugees among others).

ii. To promote and protect the human rights of people with mental and substance use disorders.

iii. To change negative perceptions of the population regarding people with mental disorders and substance abuse through the sensitisation of communities to mental health issues.

iv. To provide mental health and substance abuse services which are integrated into the entire health care system and widely available in the community.

v. To reduce institutionalisation of people with mental and substance abuse disorders.

vi. To decentralize authority, resources and services for mental health care, allowing for more participatory decision making at the primary health care and community levels, including the engagement of consumers and family members.

Areas for action and priorities

I. Coordinating Unit

The mental health programme, led by the national mental health coordinator, will coordinate all the mental health activities in the country, including supervision and collaboration with:

- NGOs and related institutions involved in rendering mental health activities/services in the country;
- The Association of Traditional Healers in Mental Health, registered with the National Traditional Medicine Programme.
- The 6 Divisional Health Teams, Health Centres, Village Health Workers and Community Based Organizations.

In addition, the Office of the Mental Health Coordinator will be responsible for fostering **inter-sectoral collaboration in sectors outside health** including government sectors such as social welfare, housing, education, employment/labour, justice and the Department of State for Youths and Sports as well as NGOs and community organisations such as faith based organizations, media (radio, television and newspaper), business organizations, traditional healers groups, women and youth organizations. Some

of the policy directions that need to be discussed and agreed upon with the different sectors are summarized in annex 4.

The co-ordinator will be supported to carry out his/her work by a 'multisectoral' technical advisory committee representing key staff from the different government sectors and NGOs, as well as health workers representing the different levels of service delivery, service users and family representatives. Representatives on the committee will be appointed by the Department of State for Health and Social Welfare in consultation with the Director of Health Services. The advisory group shall meet once every 6 months or when an important policy direction needs to be decided upon.

II. Financing

It is recognized that that the mental health and policy and strategic plan can not be implemented in full without adequate and sustained financing

The government will commit to providing a budget to maintain a central coordination role for mental health activities in the country and a basic supply of psychotropic medicines. The government will commit to finding additional sources of funding to implement mental health activities defined in the policy and plan. The resources will be mobilized from Technical Co-operation, foreign donor agencies, and from other bilateral and multilateral organizations. Mental health will be covered in any health insurance schemes set-up.

III. Legislation and Human Rights

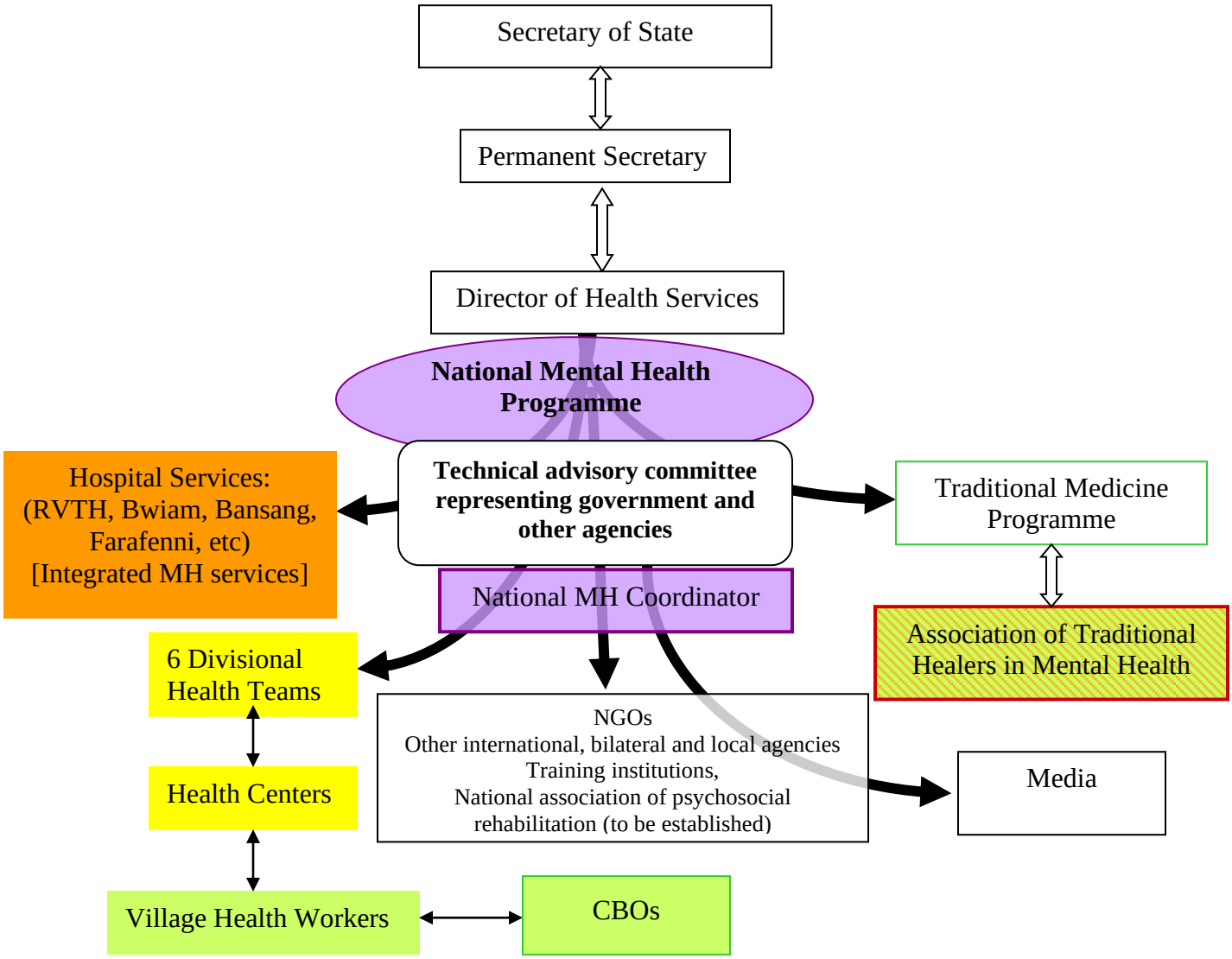
The government will reform the mental health legislation (formulated in1939 and amended in 1964) in consultation with all relevant stakeholders. The new mental health legislation will be a useful and effective instrument to improve the situation of people with mental disorders and ensure their protection against human rights violations as well as the promotion of autonomy, liberty and access to health care.

The new Mental Health Legislation will make provisions to promote: Confidentiality, Informed consent, equal access to care, conditions in mental health facilities, appropriate and accessible care in the least restrictive environment in their community, safeguards to protect against abuse, equal opportunities to/for employment and shelter/housing; and equal access to justice amongst others.

Other laws impacting on the rights of people with mental disorders will also be reviewed and updated.

IV. Organization of Services

Figure 1: Description of the Planned Mental Health Services



This policy commits to provide better coordination of care and more equitable access to treatment for people with mental disorders by providing inpatient and outpatient services in the general hospitals and the major health centers. Both general hospitals and the major health centers will also provide adequate outpatient services for those with mental health disorders. Outpatient services will be provided at minor health centers.

At the village level, outpatient treatment and care of people with mental disorders will be provided in collaboration with families, CBOs, village development committee. Families will be considered partners in mental health care and will be offered appropriate education and training. Traditional healers will be involved in the prevention, early

detection and care of people with mental disorders in collaboration with formal mental health services. Community health workers shall help to identify people with mental disorders, make an initial assessment and appropriate referrals to the major health centers (or minor when appropriate) and/or divisional heath team. Community health workers will also be responsible for following-up and supporting patients and their family when they return to the community. They will also be supported to monitor the collaboration between traditional/religious healers and formal mental health care services in order to optimize benefits for people with mental disorders and their families.

Integration of mental health care services will be accompanied by decentralization of authority, resources, services and responsibilities from the central level to the primary and community care levels. Decentralization will occur in phases, starting with the **onsite** training of health workers in the community, villages, minor health centres, major health centres, and general hospitals

Trained staff (doctors and trained psychiatric nurses) will be deployed to general hospitals and major health centres within the country and the present outpatient facilities and services will be upgraded.

A national association of psychosocial rehabilitation, comprising representatives from all the advocacy agencies, will be set-up. The main role of the association will be to collaborate in rehabilitation activities and to disseminate information and sensitize the community on metal health and substance abuse activities

The role and responsibilities of the different service levels and the health professionals working at these levels is further detailed in annex 5. Central to the re-organisation of services and the effective treatment of people with mental disorders, is the availability of psychotropic medicines at the different levels of the health system and the training of the health workers who will be prescribing these medicines. This is elaborated in the current policy document under the subheading ' procurement and distribution of essential psychotropic medicines' and also in the section on human resources and training.

V. Human Resources and Training

Training of Health Workers

Investing in human resources is essential to mental health services which rely on the skills, knowledge and motivation of their staff. Training programs will be conducted to improve the knowledge and competencies of health workers to detect, treat and support people with mental disorders. They will also address the need to change the role and orientation of psychiatrists and other health workers engaged in mental health care towards a more social and team-based approach. The proposed role and functions of different health workers are summarized in annex 5. Key health workers from each level of the health system including general hospitals, divisional health teams, major health centers and minor health centers, will be targeted for training sessions. Before any further training is planned in The Gambia, an initial assessment will be undertaken in order to identify training needs in all the facilities.

The Office of the Mental Health Coordinator, in collaboration with academic institutions, shall be responsible for the assessment of training needs, the development of training modules and the training of all cadres of health workers in mental health and substance abuse issues. In addition, the mental health coordinator, in collaboration with academic institutions will be responsible for integrating modules on mental health and the prevention of substance abuse into the training curriculum for health workers (such as Doctors, Nurses, Social Workers, Occupational therapists, Public Health Officers and Nurse Attendants).

Training of Non-Health Workers

The coordinator of mental health services will be responsible for ensuring the effective training of non-health workers including, chiefs, police, traditional healers, legal professions, religious leaders, teachers and community leaders. Training in mental health will be conducted, through seminars and workshops, and will aim to provide an appropriate level of knowledge and skills for the identification of people with mental disorders and their referral to appropriate level of the health service for treatment and care. Additionally, training will aim to increase their awareness and knowledge of the human rights of people with mental disorders and their role in relation to the planned enactment of a new mental health law. Further roles and responsibilities are set out in annex 4 and 5.

VI. Procurement and Distribution of Essential Medicines

Effective medications make it possible for people with mental disorders to live active productive lives in the community. The most cost-effective drugs with minimal side effects will be procured and distributed to all health facilities in a way that maximizes benefit to those who need them. This requires a sustained supply of essential psychotropic medicines and protection of budgets and distribution networks for these medications. Protocols for the correct administration and monitoring of medications will be established. Health workers at all levels of care will receive the appropriate training and supervision to manage the prescription and monitoring of psychotropic medication.

VII. Quality Improvement

In order to achieve the vision of this mental health policy, it is essential that the quality of mental health services is improved and maintained. High quality care means that the latest evidence-based interventions are provided for mental health at all service levels. It also implies that the available resources are used in a cost-effective way, and that services remain accountable to those who use them.

Towards this end, national quality standards for mental health care will be developed in consultation with all relevant stakeholders. Facilities will be regularly reviewed, assessed and accredited. Clinical protocols will be developed at all levels of care.

VIII. Information Systems

Key mental health indicators will be integrated in the Health Management Information System (HMIS) of The Gambia in consultation with managers, mental health specialists, health service providers and service users. This will require patient record forms to be designed or modified in facilities where data will be collected, the standardization of data collection, processing and analysis for mental health across all health centers. Relevant staff will be trained to collect, process and report on the information. Some of the core data to be collected at each service level will include; basic patient demographic information; diagnosis; type of medication and other treatment, number of visits and clinical outcomes. Additional data relevant to specific facilities will also be collected.

IX. Advocacy

Actions will be taken to raise awareness about mental and substance abuse disorders as well as their effective treatment, to change the negative perceptions of the public about people about people with disorders, and to improve their human rights. Active collaboration will be sought. Partnerships will be developed with NGOs, traditional, religious, and other community leaders, women and youth groups, to assist these advocacy efforts.

The media will be a primary tool in awareness raising and advocacy efforts and the Office of the Mental Health Coordinator will facilitate these advocacy actions.

X. Research and Evaluation of Policies and Services

Monitoring and evaluation are the key processes used for determining whether the goals set in the policy and plan are being realized and for allowing decision makers to make short and longer term service and policy related decisions and changes. It is therefore the intention of the Department of State for Health and Social Welfare to evaluate the current policy and its implementation through the strategic plan and to make changes to the policy and plan if they are not having their desired effect.

The implementation of the policy via the strategic plan will be evaluated on an ongoing basis via an examination of whether activities are being carried out as intended and whether the desired outputs are being produced. Additionally, evaluation of the achievement of strategies will be assessed in terms of whether targets and indicators for each have been achieved. At the end of the first 5 year period the policy and plan itself will be evaluated for its relevance and appropriateness as well as the degree to which each of the policy objectives had been met.

A resource center for research and training will be established in the office of the mental health coordinator. Research should be coordinated by the health systems research unit of the Department of State for Health and Social Welfare in collaboration with other research institutions.

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ANNEXES

Annex 1
ACKNOWLEDGEMENTS

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Annex 2
SITUATIONAL ANALYSIS

1. Country Profile

➲ Location and demographics

The Republic of The Gambia is located in West Africa with a population of around 1,517,000 million people (World Health Report 2006). The two primary sectors of employment and revenue are agriculture and tourism, accounting for 2.2% and 11% respectively. The Gambia is one of the least developed countries in the world with a per capita gross domestic product (GDP) estimated at US $456 (1998), ranked 149 out of 161 countries as stated in the Human Development Index of the United Nations Development Programme (2001). Approximately 20 years of drought in the Sahel and other contributing factors have contributed to 34% of the population living below the poverty line and 18% of the population extremely poor (see annex 6).

The estimated annual population growth rate of The Gambia is 4.2 percent. Population density is slightly more than 97 people per square mile, making The Gambia the fourth most densely populated country in Africa. The above-mentioned factors depict a bleak situation for the health care system of the Gambia, especially mental health.

The proportion of population under the age of 15 years is 40% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 43.7% for men and 29.7% for women (UNESCO/DoSH, 2004). The per capita total expenditure on health is 78 international dollars, and the per capita government expenditure on health is 39 international dollars (WHO, 2004). The official language used in the country is English. The largest religious group is Muslim (comprising approximately 95% of the population), Christian (comprising approximately 4% of the population) and Animist (comprising approximately 1% of the population). The life expectancy at birth is 55.4 years for males and 58.9 years for females (WHO, 2006). The healthy life expectancy at birth is 48 years for males and 50 years for females (WHO, 2006).

➲ Socio-cultural context

Understanding the impact of the cultural context in which people with mental illnesses and their families live is essential to understanding the potential barriers to the development, delivery and acceptance of mental health care services. The Gambia has five major ethnic groups: Mandinka, Fula, Wolof, Jola, and Sarahuleh. From ancient times to the present, the Gambian culture views the causes of mental disorders in three main forms:

1. As arising from demon or witchcraft possession or punishment by supernatural forces. *For example, many of the Fula people believe in a disorder called 'Dowdi' which they believe arises as a result of a curse imposed by traditional healers, (called Marabout). 'Dowdi' is defined by a collection of somatic, behavioral and cognitive signs and symptoms, which are indistinguishable from, generalized anxiety disorder by ICD (International Classification of Disorders) or DSM (Diagnostic Statistical Manual of Mental Disorders) criteria.*

2. As arising from conflict, stress, or moral weakness.

3. As arising from imbalances of bodily fluids and the belief that mental disorders may arise from an 'infectious agent'. *For example, many groups in Gambia believe that contact with the bodily fluid of an individual suffering from epilepsy will result in their contracting the disease themselves.*

Many people have very little knowledge about mental disorders and are unaware of the availability of simple and effective preventive, treatment and rehabilitative measures. Many Gambians believe that people suffering from mental disorders will never get cured; that they will never be productive members of society; that there are no effective treatments; that all mental disorders are the same; that mental disorder is a punishment for which recovery is unlikely; and that those who work with people suffering from mental disorders will themselves become 'crazy'. Many of these erroneous beliefs or misconceptions are held not only by patients, families and communities, but also by health professionals working in both general and mental health services, as well as by individuals within government agencies.

These myths perpetuate both stigma and discrimination against the mental disorders giving rise to social adversity, pervasive negative attitudes and prejudices, and at times, the condemnation of people with mental disorders. As a consequence communities (including health workers) are cautious towards those with mental health problems; families are ashamed of having a member with a mental disorder; and resource allocation for people with mental disorders has been negatively influenced. Although these beliefs are slowly changing, the prejudice against those suffering from mental disorders in terms of lack of inclusion and services still persists.

➲ Economic Context and Consequences for Mental Health Situation

Poverty remains a pervasive problem in the country. Poverty, poor housing, inadequate access to basic health services and educational facilities, insecure jobs and low salaries are the living conditions for a large proportion of Gambians. It is predicted that there will be a continuing rapid trend towards rural – urban migration, influx of refugees, seasonal and economic migrants. Pressures and increasing scarcity of opportunities will create tensions and misunderstandings. Host and migrant groups will compete for jobs and business opportunities. These events can perpetuate existing psychological, social and economic problems within the country and increase the risk of mental problems as well as illicit substance abuse. Tackling these problems to prevent human potential from being destroyed or directed into illicit activities is urgent.

As there is a vital connection between poverty and mental ill-health, the policy recommendations in this document highlight the need to improve conditions for people living in poverty and to address the enormous burden resulting from untreated mental and substance abuse disorders and also to ensure that mental health interventions take into account some of this reality. Addressing mental health problems will require political commitment at the national and divisional levels. This requires more national efforts to improve the standards of living, good mental health services and viable self-sustaining economies in the country.

2. Epidemiology of Mental Disorders

Communities in the Gambia are faced with numerous, mental, neurological, and psychosocial disorders that undermine development. Based on prevalence rates from the World Mental Health Survey, 2004 it is estimated that approximately 27,000 people in the Gambia (or 3% of the population aged 15 years and more) is suffering from a severe mental disorder and a further 91,000 (or 10% of the population aged 15 years and more) are suffering from moderate to mild mental disorder. This means that at least 118,000 people in the Gambia (or 13% of the adult population) are likely to be affected by mental disorders which require varying degrees of treatment and care.

The above figures may even underestimate the prevalence rates in the Gambia. A situational analysis of the mental health problem in the urban and rural populations of The Gambia report conducted by Olufemi Morakinyo (Mental Health Consultant), Professor of Psychiatry, Department of Mental Health Obafemi Awolowo University, ILE-IFE, Nigeria, state that the prevalence rate of the somatoform disorders among adults aged 15 and above was estimated to be 7.5%, followed by mood disorder – 6%, and anxiety related disorders 5.2%. These three, account for a prevalence rate of almost 20% one out every 5 persons aged 15 or more. This is comparable to other developing countries including Nigeria and Uganda. Drugs and alcohol abuse were also highlighted as increasingly serious mental health issues in the Gambia, with 6-8 persons out of every 100 in Kanifing and Kombo North Districts categorized as alcoholics. Use of illicit drugs was also noted to be high, though likely under-reported at an average of 5%, with rates as high as 10% in Kombo Central. 37% of prison inmates interviewed reported illicit drug use report of 1994 –1996 nation wide pilot study.

There is a large gap between the numbers of people affected by a mental disorder and those receiving treatment. While the prevalence rate is estimated to be between 27,300 (severe disorders) and 91,000 (all mental disorders) the maximum number of people receiving treatment in 2005 was estimated to be 3,278. In the years 2003 and 2005 there were approximately 1,207 and 1, 424 annual admissions for treatment to the Campama psychiatric unit of the Royal Victoria Teaching Hospital respectively. Additionally, a total number of 1,654-1,854 patients received outpatient treatment in the five divisions for the years 2004 and 2005 respectively. This data is described in some more detail below.

Admissions to Campama Psychiatric unit: In 2003, 1207 patients were admitted, 449 were new admissions and 758 were readmissions. Out of which a total of 762 were discharged home, 4 of the patients passed away and 101 absconded. 864 were Gambians and 342 were non-Gambians. The records for the year 2004 were not available in the Hospital records office. In 2005 1,424 patients were admitted out of which 5 patients passed away. 732 were discharged home while 104 absconded.

Outpatient treatment in the five health divisions: The records from Health Management and Information System at the Department of State for Health from 2004 to 2005 in the five divisions show that a total of 1,654 and 1,954 patients were registered at the general out patients departments for the years 2004 and 2005 respectively. The data is limited in that it does not detail the types of mental disorders nor whether the cases were new cases or not. The table below shows the distribution of patients registered at the general outpatients departments in the five health divisions.

Table 1: Number of patients with mental disorders registered at the general outpatient department in the 5 health divisions (years 2005 and 2006)

Health Divisions	Year 2005	Year 2006
Upper River Division	**360**	**371**
Central River Division	**166**	**205**
Lower River Division	**76**	**235**
North Bank Division East	**264**	**125**
North Bank Division West	**363**	**315**
Western Division	**425**	703
TOTAL	**1,654**	**1,954**

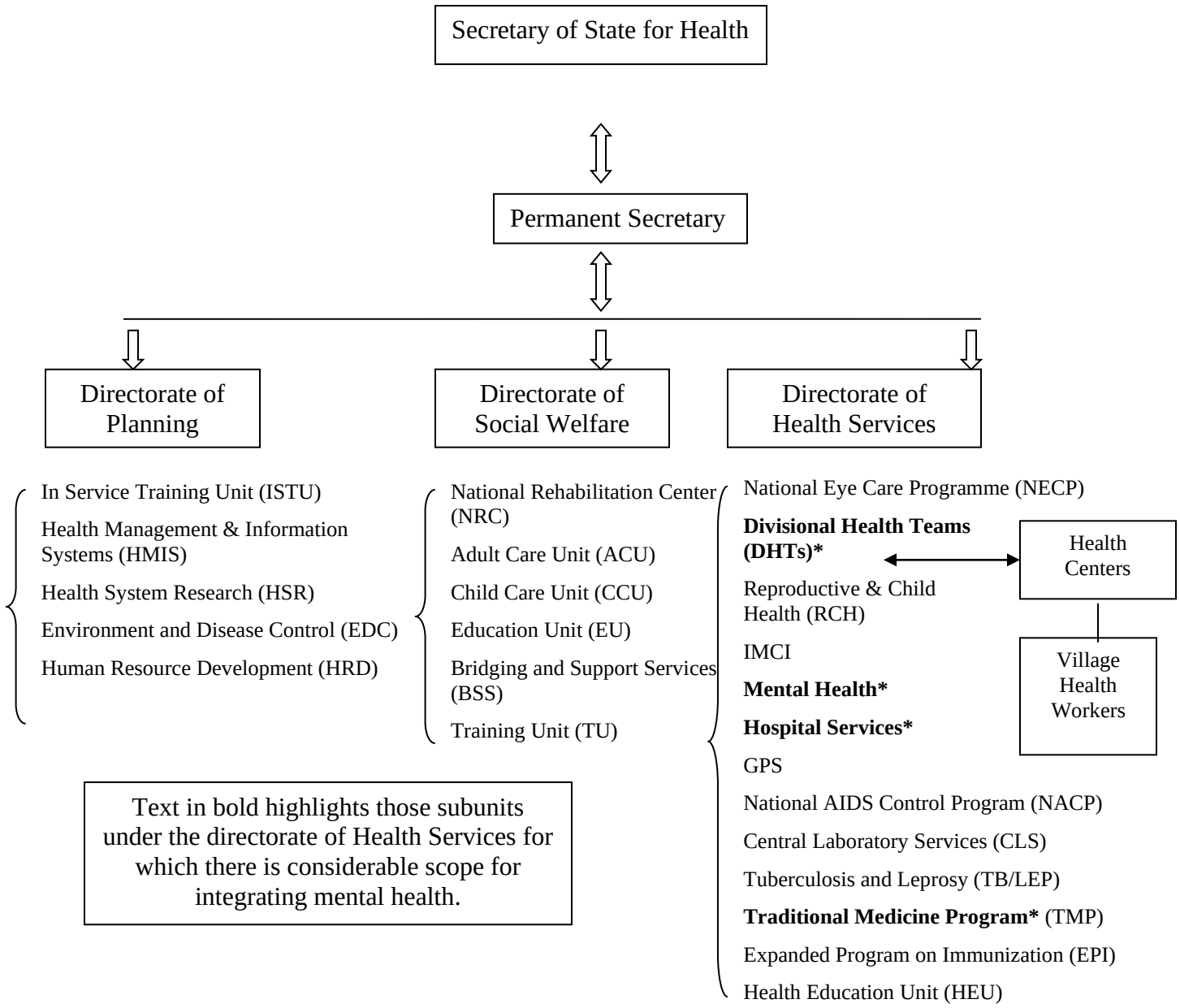
3. Description of current General Health System & Services

➲ Organizational structure

The chart below shows that the Secretary of State for Health is the executive head of the Department of State for Health and Social Welfare, followed by the permanent secretary who has three directorates under him, namely: Directorate of Planning, Director of Health services and Director of Social Welfare. These three directorates are responsible for the various subunits of the department of health services.:

- The **Directorate of planning** is responsible for health systems development, human resources development and the allocation of resources to health services and programs and salaries with allowances to designated positions
- The **Directorate of social welfare** looks into the psychosocial needs of people including housing, family and community support. The director is responsible for the overall administration of the various units under the department.
- The **Directorate of health services** is responsible for all health services (including mental health) being delivered in the Gambia, through the various Units under him/her as indicated in the chart below:

Figure 1: Description of the General Health System and Services



➲ Organization of General Health Services

The type and distribution of health services in the Gambia are represented in map 1 and are described below.

- **Public/Private sector mix**: There are 34 private and non-govt clinics. Public sector has 1477 beds, there is a total workforce of 3,253 in health sector and roughly 45% are working in the 4 public tertiary hospitals, 25% in the divisions; 26% in private sector and 4% at central level: some of this information conflicts with the info below (The Republic of The Gambia - Policy on Human Resources for Health (2005-2009)).

- **General hospitals**: There are 6 general hospitals which are managed by semi-autonomous hospital boards. They all provide inpatient services for all health conditions except for mental health (Royal Victoria hospital has an inpatient unit for mental health but this is provided on separate premises quite independently of the other hospital services). Each hospital has an outpatient department and deals with the wide ranging health issues and to a limited degree it deals with mental illness. The core staff at each of the 4 hospitals is represented in the table below.

Table 2: Staffing of General Hospitals

Staffing numbers in each hospital	Admin including CEO	Pharmacy	Lab	Medical doctors	Matrons	Nurse attendants	Support services
Hospital 1 - AFRRC	21	5	6	2		47	36
Hospital 2 - Bansang	18	9	10	7		45	79
Hospital 3 - JFP	2	1	1	3		24	11
Hospital 4 - RVTH	45	30	40	60	9	160	104
Hospital 5 - SJGH	10	1	9	12		16	28
Hospital 6 – Nb Serekunda Hospital is opening in Jan. 2007	--	--	--	--	--	--	--

- **Six Divisional Health Teams** (one per catchment area) are located in the key town of the 6 main divisions. These teams travel around and regularly visit the different health facilities within their respective catchment area. They are the administrative head of all health facilities. They have their own pharmacy store, with a limited number of psychotropic medicines. They have scheduled days for visits (clinical consultations) in health centres but patients can have access to medicines any day from every health centre's (major and minor) pharmaceutical store. The composition for each divisional team is as follows: 1 divisional public health nurse, 1 divisional public health officer; 1 community health nurse supervisor and 1 divisional pharmacy assistant and divisional accountant –linked to drug revolving fund. Each Divisional Health Teams is headed either by a Divisional Health Officer (either a public health officer or nurse). There is also some support staff attached to the team (drivers, secretary and logistics staff).

- **Seven Major Health Centres** are located in the main town or villages of each of the districts in the Gambia. Their main functions are to carry out minor operations, basic laboratory investigations and to deal with major uncomplicated health issues. They also have outreach services to the health posts based in the primary health care key villages.

Their staffing is reflected in the table below:

Table 3: Staffing of Major Health Centres

Staffing numbers in each major health centre	Admin / OIC (officer in charge)	Pharmacy technicians	Lab	Medical doctors	SRN / SEN / CHN	Nurse attendants	Support services
Major Health centre 1 Brikama H/C	1	3	6	5	15	10	15
Major Health centre 2 Basse H/C	1	2	4	4	13	8	10
Health centre 3 Soma H/C	1	2	4	4	10	9	9
Health centre 4 Faji kunda H/C	1	3	4	4	8	10	8
Health centre 5 Kudang H/C	1	1	2	3	8	6	7
Health centre 6 Kaur H/C	1	1	1	2	6	6	6
Health centre 7 Kuntaur H/C	1	1	1	2	6	6	6

- **30 Minor health centres:** consist of an outpatient department, a labour ward, and an inpatient unit for acute admissions. Only patients not responsive to treatment at this level are referred to the major health centres or to a hospital. Composition of the minor health centers is between 6 and 8 SRNs, SENs, CHNs; between 5 and 6 nurse attendants, between 4 and 6 support service staff, and between 1 and 2 public health officers.

- **492 Health posts:** Each is based in one of the 492 "primary health care villages" (there are over 1,000 villages in the Gambia). The primary health care village usually reaches out to 4 to 6 neighbouring "satellite villages". There is no fix staff working there but monthly clinical visits are organized from the closest minor and/or major health centres and health workers from these centres can come and give consultations on request (of the community health workers and/or the head of villages). They can also provide consultations at home when needed.

- **Primary health care villages:** In each primary health care village there is a village development committee who works with community health workers like traditional birth attendants, village health workers and community health nurses; they live and work in villages. Their main role is to raise awareness, educate, promote community participation and refer where necessary to the next level (minor and major health centres) and their catchments' area's Divisional Health Team. They have motorbikes so they can go and work in "satellite villages".

- **Informal care services:**

This includes the services provided by traditional and/or religious healers, and over 30 NGOs working in health in the Gambia.

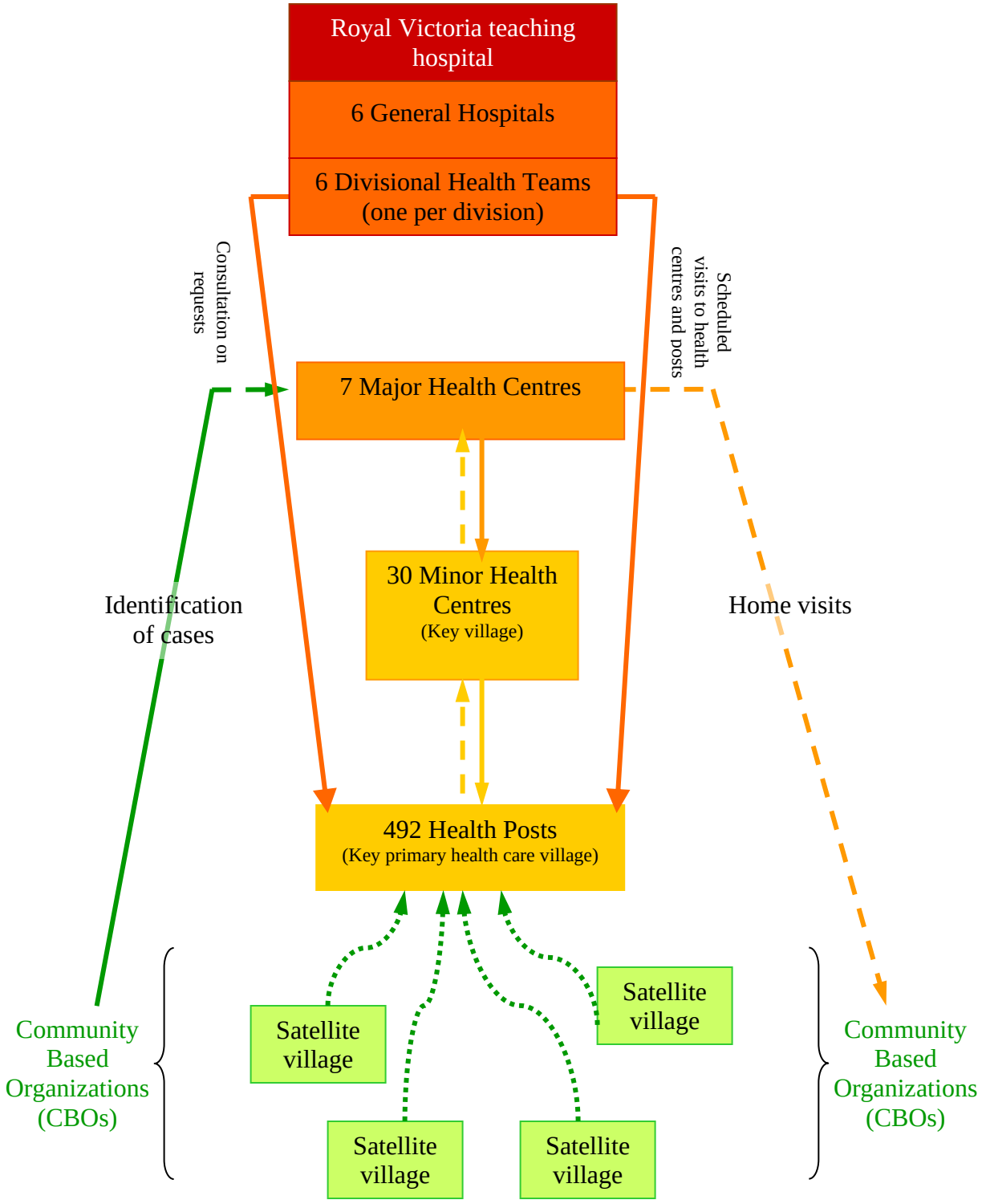


Figure 2: Health Services in the Gambia

4. Description of current Mental Health System & Services

4.1. Coordinating body – the Mental Health Unit

The Mental Health Unit at central level is a recently established structure and its major role is to work in close liaison with other health units in order to better coordinate mental health services and activities nationally. Given the important link between mental heath and physical health and social welfare, the mental health unit has an important advisory role to play to other units.

As an example, the Health Education Unit at Central Level in collaboration with key mental health experts has played an important role in sensitizing the community about mental health issues on Community Radios and on National Television.

4.2. Long stay facilities – Campama psychiatric unit

The Campama Psychiatric Hospital was established in the early 1970s. It is the only residential stand alone psychiatric institution in the country.

The Campama Psychiatric Unit is a five building complex building divided into two-acute/admission wards (female and male), administrative and recovery wards, occupational therapy complex, a multipurpose room and an office for the Community Mental Health Team. Currently it provides inpatient services (Campama Psychiatric Unit)) to the entire nation and until 2005 it provided a basic community-based service via the Community Mental Health Team based at the hospital.

There are currently 70 residents living in the Campama Psychiatric Unit: 20 females and 50 males ranging in age from 18 to 55 years. 30% of residents are long stay patients. The total bed capacity of the institution is 64, 25 female beds and 35 male beds. However, available rooms are grossly overcrowded with 2-3 patients per room.

The unit has 2 single toilet facilities for staff. For patients in the male wing there are 6 toilet facilities and 6 showers. For the females there are four toilets and four showers. They are all in bad condition, many non-functional There is one large multipurpose room for dining area, large occupational therapy/recreation room and surrounding garden area, open shared central garden space, nursing station, staff office (which doubles as an assessment room) with a separate kitchen, laundry and an admissions area.

There are no privacy curtains and conditions preclude attempts to respect resident's personal space. The floor plan of the hospital does not meet basic patient safety or care needs. The position of the nursing station does not allow for observation of either male or female wards nor recreation, dinning or surrounding areas. The physical structure of the Campama hospital is in significant disrepair. Although there is significant space within and outside of the physical structure much of this space is not utilized.
There are 5 'lock down' rooms. These are large empty (save a foam mattress) concrete rooms with a single steel door (many of which have been partially destroyed or 'kicked in' by patients leaving dangerous sharp protruding metal at many of the door bases) and

rusted barred window. Although these rooms were built within the past 12 months their physical design is punitive and incompatible with basic standards respecting safety, human rights and dignity. These rooms **are not** therapeutic quiet rooms.

The facility is surrounded by a gate which is constructed more to protect the surrounding from the patients rather than for the protection of the patients themselves. Patients are able to abscond by climbing the gate and walls at various points out of sight of facility security and are able to purchase drugs from individuals outside by passing money and substances back and forth across and through holes in the walls.

Nursing staff shortage at the Campama Psychiatric Unit significantly interferes with the provision of patient care. Care is purely custodial in nature with little opportunity for structured recreational, rehabilitative or other therapeutic activities.

Type and number of staff[1] based at Campama Psychiatric Unit is as follows:

Table 4: Staff in Campama Psychiatric Unit

Professional staff	**Responsibilities**	**Number**
Psychiatrist[2]	Clinical	2
Matron	Administrative and clinical	1
Nursing Officer	Clinical	1
Junior staff nurse	Clinical	4
Nurse attendants[3]	Clinical support	7
Total Professional		**14**
Non-professional staff	**Responsibilities**	**Number**
Ward Clerks		1
Record Clerk		1
Laundry		3
Cook		3
Orderly		8
Generator Operator		2
Security		4
Total Non-Professional		**22**

Inadequate access to and provision of general health care services to patients of the Campama Psychiatric Unit has been a longstanding and recurrent concern. Staffs do not have direct access to basic or specialist medical aid in the event of an emergency.

[1] Staffing levels are in constant fluctuation due to staff leaving, rotating or technical assistants (TA) arriving from other countries. Technical assistants might be a psychiatrist or nurse. They get paid a salary package as part of a bilateral cooperation agreement.

[2] Current psychiatrist is Cuban trained. A Nigerian psychiatrist is expected soon.

[3] On the job trained nurse.

Ambulance services to and from the Royal Victoria Teaching Hospital are unreliable and long delays in response time are the rule rather than the exception.

Health records at the facility are clear and informative. Each chart contains a full admission history and progress and nursing notes consistently contain the relevant, necessary information for the transfer of pertinent clinical information between and among health professionals.

Despite longstanding physical plant and human resource issues, many of the staff of the Campama Psychiatric Unit has demonstrated a remarkable resilience in their dedication and investment to caring for the residents.

To sum up, the Campama Psychiatric Unit functions as a stand-alone custodial care institution. Its current physical plant and functional program promotes and perpetuates the stigmatization and discrimination of the mentally ill. The physical plant is in dire need of repair and the service has inadequate human and material resources to meet basic care needs including patient dignity, safety and privacy.

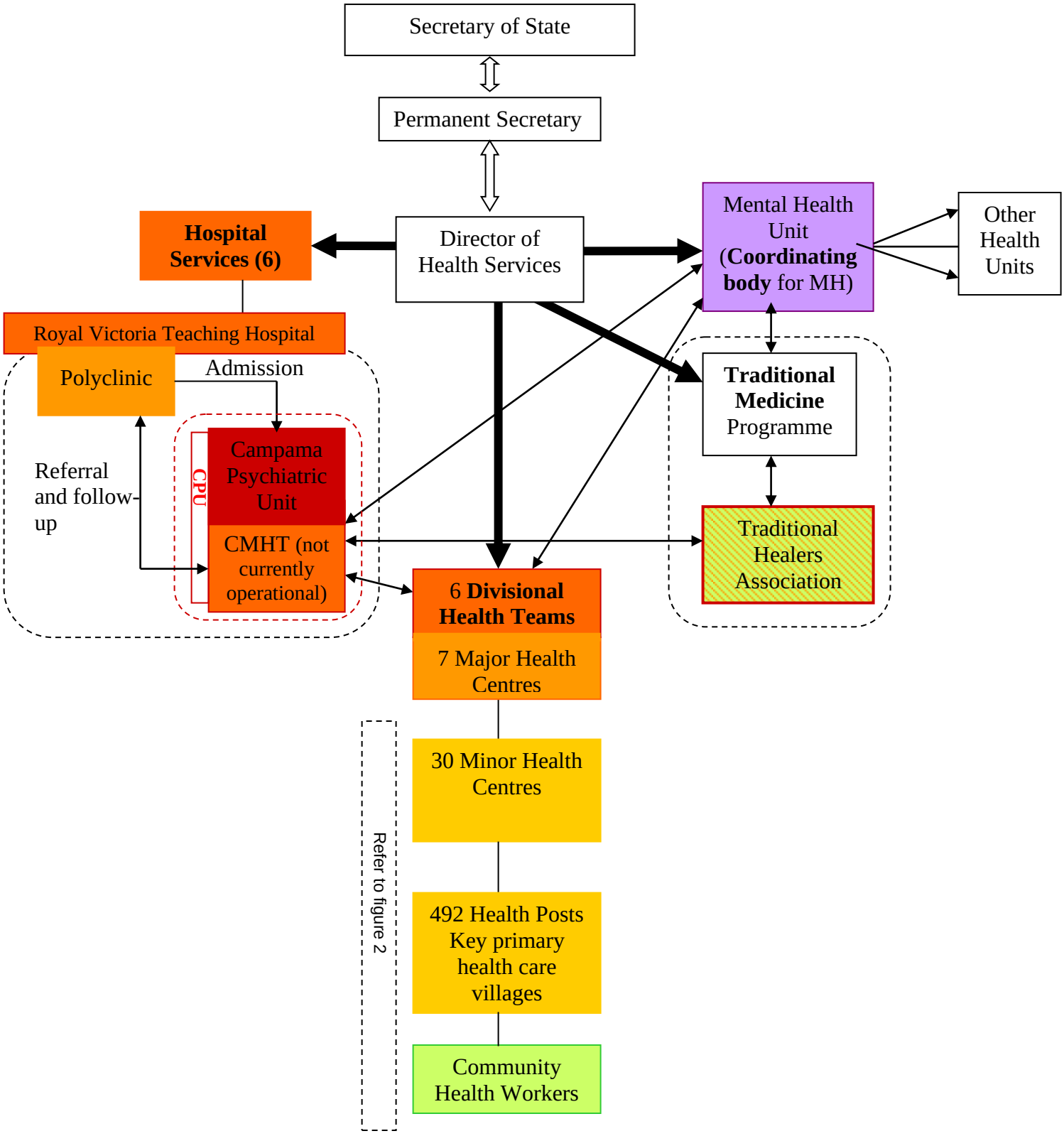


Figure 3: Current Mental Health System in the Gambia

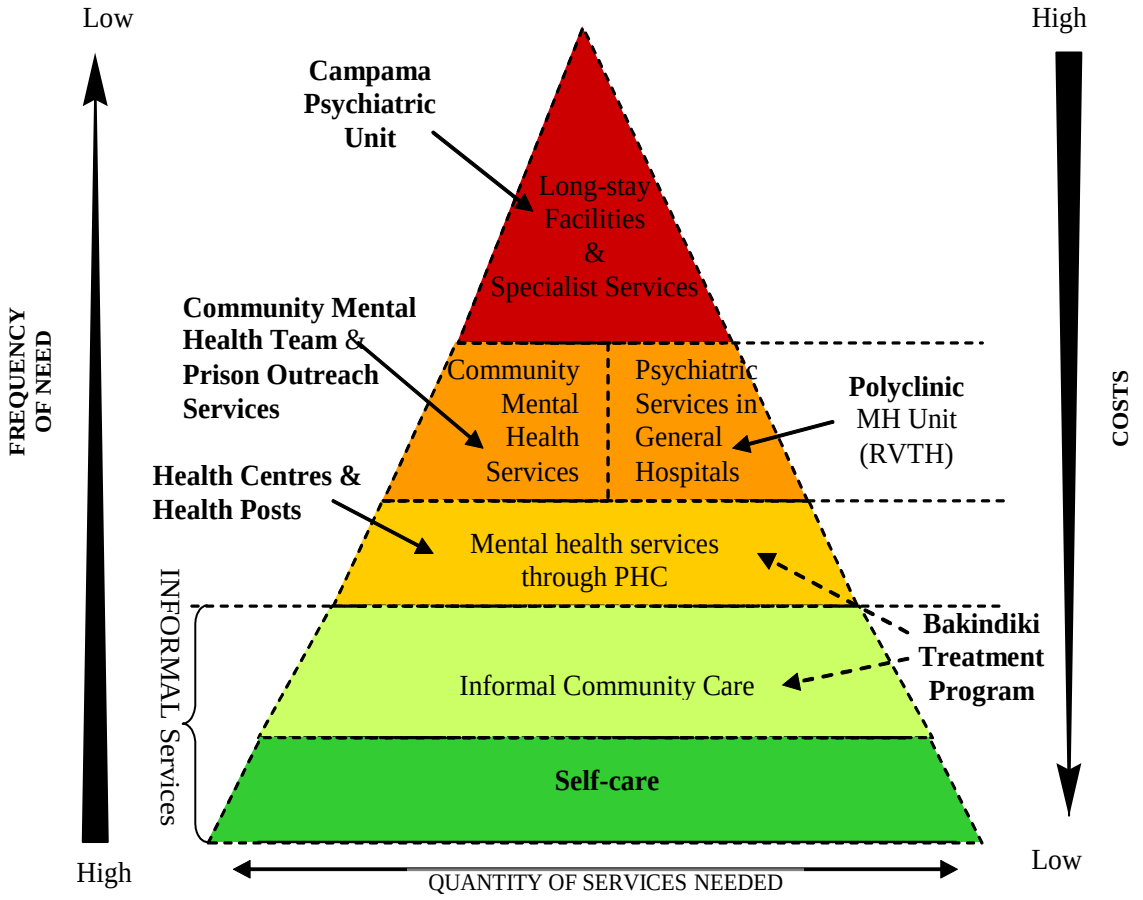


Figure 4: WHO Model Pyramid applied to the Gambia

This figure shows WHO recommendations for optimal use of services and how services currently existing in the Gambia map on to this optimal mix framework.

4. 3. Community mental health services (Secondary level)

Community mental health services had been set-up during the period 1993 to December 17, 2005. These services were delivered predominantly by the community mental health team based at (essentially a sub-unit of the) Campama Psychiatric Unit. The team was headed by an Advanced Psychiatric Nurse Practitioner and deputized by a Registered Psychiatric Nurse, with one State Enrolled Nurse, Community Health Nurse and a Nurse attendant and a driver as team members.

- **Outreach Services to the Prison**: During the time in which the Community Mental Health Team was operational they used to provide mental health services to the prison on a monthly basis. Care components included diagnostic assessment, medication treatment intervention, monitoring and follow-ups. This service is no longer operational.

As of November 2005, there were 500 inmates (485 men and 15 women) at the prison facility. Approximately 20 of these inmates (all male) have a diagnosable mental disorder requiring treatment (psychotic disorder the most common diagnosis). 15% of these individuals were incarcerated for capital crimes; 85 % for petty crimes. At the present time there are no formal or informal links with general medical care services for inmates and no ambulance service.

Prison staffs do not have the knowledge nor the skills to assess, monitor or manage mentally-ill inmates. Only one staff member has received some form of orientation in relation to mental disorders through a 1 month observation placement with the mental health care team at the polyclinic and the Campama Psychiatric Unit – none have received training in the management of psychiatric emergencies or how to manage patients demonstrating out of control or violent behaviour.

Inmates suffering from mental disorders share the same quarters as the rest of the inmates. Difficulties arising from this include frequent physical and verbal altercations between inmates without and those with a mental disorder and exploitation of the mentally ill is also of concern.

No aftercare or continuing care services are offered and there is no requirement to inform mental health services of inmate discharge. Therefore, patients with mental illness in prison are often discharged to the community without assessment or follow-up by psychiatric services.

Staff at the prison advocated for the development of a separate facility and service for mentally ill inmates on prison grounds and the provision of onsite access to regular mental health care specialists

- **Outreach Services to homes**: In addition to these population-based interventions, health workers of the CMHT were available to go and visit people with mental disorders in their home and community whenever there are claims about mistreatment and/or problems with the family/community. Claims can come from the patient during the consultation or from people from his community (head of the village, police officer, employer, member of the family, etc). Health workers try to understand where the problems lie and how to help with a better acceptance and rehabilitation of the people with mental disorders in his community.

- **Services at village level**: Community health workers like traditional birth attendants and village health workers have an important role in raising awareness, educating communities on health issues and referring cases to the next referral levels. However, their potential role has not been utilized to full capacity in relation to mental health.

4.4. Psychiatric services integrated into general hospitals

- **The Polyclinic of the Royal Victoria Teaching Hospital**: The polyclinic has a unit (single room) allocated for outpatient mental health services, which is headed by a Psychiatrist and assisted by a nurse attendant.

The Unit provides curative and preventive services to all outpatients who come for monthly follow-ups. It also serves as the first point of call for almost all patients admitted at The Campama Psychiatric Unit (both new cases and re-admissions). This Unit provides services during weekdays only between the hours of 8am to 2pm. Approximately a total of twenty to thirty patients are seen per day.

The Polyclinic is integrated within the Royal Victoria Teaching Hospital and is administratively independent of the Campama Psychiatric Unit. People with mental disorders are sent to the polyclinic of the Royal Victoria Hospital for an assessment before being admitted to the Campama psychiatric hospital.

- **Other general hospitals**: There are limited services for people with mental disorders through the outpatient departments in the four general hospitals (Bwiam, Bansang, Farafenni and Jammeh foundation) .These services are limited to psychiatric follow-up by the general nurses attached to the outpatient departments, with the support of the medical officer in charge, who does not have specific mental health training). In the past the community mental health team would provide monthly clinical services to the staff and patients. No inpatient service is available in general hospitals.

4.5. Mental health services through the major health centers: During 1996-2005 the Community Mental Health Team (CMHT) and the Divisional Health Teams (DHTs) collaborated very closely. The CMHT used to have scheduled days for outreach clinical review visits in the 7 major health centres and minor health centers but they also intervened at anytime (depending on the degree of emergency) on the request of these health centres through the DHTs.

The frequency of visits is as follows:

- on a monthly basis in the greater Banjul area;
- on a 3-monthly basis in the 2 main other areas: North Bank and South Bank.

The major health centres have their own pharmacy store with a few basic psychotropic medicines. The CMHT, when it was operational, used to supplement these supplies with additional medicines when there was a shortfall and where patients required medicines that were not routinely stocked in these pharmacy stores. There are no specifically trained mental health workers at the major health centres.

Prior to the CMHT's scheduled visits to the major health centres, the DHTs used to sensitize their communities and announce their visit, through use of local radio and traditional communicators.

The Community Mental Health Team used to have the responsibility of outreach to the major health centres because there were few trained mental health workers in any of the Divisional Health Teams and the major health facilities countrywide. Some of the nurses at the major health centres had attended the WHO orientation workshop on the identification and management of people with mental disorders: They were also exposed to mental health treatment and care issues as part of their undergraduate course. For example, the State enrolled nurses (SEN) and Community health nurses (CHN) received one month training (1 week lectures and 3 weeks practical in the Campama unit and the polyclinic at RVT) and Senior Registered nurses (SRN) received three months training (2 weeks theory and 10 weeks practical experience including study tour to traditional healers). Despite this exposure and training on mental health issues only a small number are providing treatment and care to people with mental illness.

A total of six hundred patients are seen by the team on a monthly basis in the health facilities and approximately one hundred and fifty patients at the five collaborating traditional healers' homes (see section on informal community mental health services).

4.6. Mental health services through the minor health centers:
Only a few health care providers in the minor health facilities have the knowledge, skills and motivation to provide follow-up treatment and care for people with mental disorders

4.7. Informal community care (including traditional and religious healers)

Traditional healers are respected members of the community and first points of contact for many people with mental disorders. During the last few years the Department of State for Health and Social Welfare has been working in close partnership with traditional healers in a number of districts in order to provide treatment and care to people with mental disorders.

Essentially traditional healers, through the program are introduced to modern medications and treatment methods alongside traditional methods. The programs have been successful with good clinical outcomes.

➥ **The Bakindiki Village Treatment Program**

In Bakindiki village 4 traditional healers have been trained to identify people with mental disorders and to provide treatment (psychotropic medications and care, namely psychotropic medications. The program started with epileptic patients, but was then extended to patients with psychosis. Follow-up treatment and support is organized through the closest health center and/or through regular appointments/consultations with traditional healers. To date a total of 300 patients have been treated through the programme, with very encouraging clinical outcomes.

Similar treatment programmes are running in the villages of Buiba, Japenni, Bullock, Numu-el and Busura.

To date, a total of 15 traditional healers have been trained by the previously existing Community Mental Health Team and 12 are formally certified and working in collaboration with the office of Traditional Medicine and the Mental Health Co-ordinator, Department of State for Health and Social Welfare. Furthermore, six traditional healers, who provide "village care", where patients live in the traditional healer's home on a long term basis, receive allowances (financial incentives) from the Department of State for Health and Social Welfare for their contribution towards mental health care.

Traditional healers are provided with ongoing supervision and support by health workers. In the past the CMHT used to conduct monthly visits to the villages.

This relationship has proven beneficial to patients, families and communities in the following ways:

- Improved access to mental health services in the community
- Good treatment outcomes
- Reduction in the use of chains/logs for physical restraint of agitated patients
- Improved awareness and knowledge about mental disorders and their treatment,
- Reduction in stigma towards the mentally ill
- Improved follow-up and support of people with mental illness and their family
- Re-integration of the mentally ill within community structures

➥ **Spiritual healers**: Spiritual healers' treatment of mental disorders is mainly based on prayers and spiritual rituals whereas traditional healers use concoctions and traditional oral medications. There are 2 spiritual healers who are available for consultation at the Campama Psychiatric Unit on the request of the patient or his/her family and with the agreement of the health team but there are no active collaborations between them and the formal mental health services.

➥ **Media interventions**, through TV and Radio programmes, and pamphlets on mental health available in health centres. The operation "Save the Mind" has been led in the Gambia in 2001-2003 (see leaflet in annex 7).

➥ **School interventions** mainly consist of one week "train the trainers" workshops, for pupils to be able to identify and appropriately refer people developing mental disorders, including substance abuse.

➥ **Identification of and Collaboration with NGOs:** Many non-governmental organizations are presently making a difference in improving mental health care and reducing exclusion of those in need of help. VSO, Peace Corps and Rotary Club International have all supported the mental health program in previous years, more particularly the supply of psychotropic medicines and mopeds (small motorbikes) for community follow-up. Contributions made are not guaranteed from one year to the next and are attached to specific activities. Notwithstanding, collaboration with NGOs has

been very positive and successful. Further collaborative initiatives should be encouraged and supported.

Table 5: Summary table of NGO involvement in Mental Health in The Gambia

Non-Government Organization	Past Activities in Mental Health
Action Aid	Funding (material resources) Funding of psychotropic medicines for RVTH
VSO	Technical Assistance for service delivery - 3 volunteers in the community mental health team and 2 volunteers based at Campama – psychiatric nurses in the community mental health team (volunteers were send-in from 1992 up 1999 on two yearly basis)
Peace Corps Volunteers	Technical Assistance (one volunteer was send-in from 2002-3).
Fateleku Group (from 2000 up to date)	Support Services: - Refurbishment of Campama psychiatric Unit - Donation of materials - Participation of program implementation
Rotary Club International	Provided 8 motorcycles in 2002 to the CMHT for home visits

➥ **Consumers/User and family associations:** There are no mental health consumers/users or family or associations in The Gambia. These groups can play valuable prevention/promotion, advocacy and rehabilitative roles within the mental health care system including:

1. Public information and education campaigns
2. Fund raising
3. Financial Support
4. Emotional Support
5. Counselling
6. Community sensitization
7. Lobbying for policy and legislative change

5. Description of Human Resources and Training for Mental Health

This section provides a description of current human resources directly or indirectly involved in mental health and outlines their training.

Mental Health Workers:

Overall, qualified human health resources currently providing mental health care in Gambia are sparse, overburdened and insufficient to meet basic population mental health needs. There is a critical shortage in psychiatric trained nurses. Previously six psychiatric nurses were trained abroad but three of them have since migrated to other countries. As already mentioned there are no qualified personnel in the health divisional teams, the general hospitals, nor the major and minor health centres.

The CMHT when it was operational was responsible for teaching the mental health component of the nurse curriculum for Senior registered nurses (SRN), State enrolled nurses (SEN) and Community health nurses (CHN) at the nursing school. In service training was organized for nurses by the CMHT. Currently teaching is conducted by the Acting Mental Health Coordinator Mr. Bakary Sonko

Post qualification training has not been conducted in any systematic way except for a WHO orientation workshop held during 1997 to 2005. This workshop was a 'train the trainers' program provided by CMHT in the country and financed by WHO-Country office. This training program provided training in case identification and basic interventions (supportive and psychopharmacological treatments).

The main types of health workers, their numbers, training qualifications, and the service level in which they work are summarized in the table below.

Table 6: Title and clinical service allocation of different types of mental health workers in The Gambia

Health workers & Training in Mental Health	Clinical Service Allocation
Psychiatrists[4] (N = 3) Full-time technical assistants (N = 3; 2 Cuban & 1 Nigerian doctors, trained in their country of origin)	2 – Campama Psychiatric Unit 1 - Royal Victoria Polyclinic
General Medical officers[5] (N = 108)	84 doctors are based in the 5 main hospitals and a further 24 medical doctors based in the major health centers and some community health centers
PNOs[6] (N = 10)	1 at each of the five hospitals and the 5 others posted at central level programme units (as unit programme managers)
Public health officers (N = 59)	1 based in a general hospital 44 based in health centers in the six divisions 15 based in the divisional health teams,
Matrons (N = 9)	1 based in Campama psychiatric unit Remaining based in each of the other units of Royal Victoria hospital
Registered nurses (N = over 600)	1 Full-time at Campama psychiatric hospital Remaining based in the health facilities country wide and other private health facilities
Registered Psychiatric nurses[7] (N = 1)	1 –National coordinator for mental health
Community health nurses[8] (N = over 600)	6 based in the 6 divisional health teams (1 per divisional team) ; all the others work in the various health facilities
State Enrolled Nurses[9] (N = over 600)	2 – Campama 1 – Community mental health unit Others based at the various health facilities
Nursing Attendants (N = 439)	8 – Campama 1 - Banjul Polyclinic Table 6 was 1 - Community - where in the community?? Remaining based in the major and minor health centers
Occupational Therapy Assistants (N = 2)	Campama
Social Worker (part time staff available on request through the social welfare dept)	Where needed
(N = 1)	
Traditional Healers (N = over 1,000).	15 traditional healers working in collaboration with the mental health team of which 6 receive financial support from State Department of Health and Social Welfare.
Spiritual Healers (N = over 10)	2 Spiritual healers working in collaboration with the Mental Health team.

[4] Post graduate training in Psychiatry in their country of origin

[5] Twenty of them have participated in the WHO orientation workshop in mental health.

[6] PNOs are trained SRNs with post graduate training in various fields of nursing.

[7] Registered psychiatric nurses undergo the training for registered nurses. In addition they have a further 9 months specialty training in psychiatry. Training generally undertaken outside the country.

[8] State enrolled nurses (SEN) undergo a nursing course for 2 years. During this time they receive 4 weeks training in mental health treatment and care (1 week of lectures, 3 weeks practical training in Campama Unit and the Polyclinic). Twenty-five have participated in the WHO orientation workshop in mental health.

[9] Community health nurses (CHN) receive the same training as State Enrolled Nurses; 15 received WHO orientation

Non-health workers

Non-health professional groups, for example, prison staff, traditional healers, health journalists, and military officers have participated in a one week orientation workshop based on the identification, first line management and referral of people with mental and behavioural disorders in the communities during 1997 and 2005. The workshop was sponsored by W.H.O-Gambia Office as part of the biennium plan of action in collaboration with the Department of State for Health and Social welfare.

Table 7: Type of training available to non-health workers in The Gambia (1997 to 2005)

Non-Health Workers	Type of Training	Numbers trained
Prison Staff	One month clinical observation in the Polyclinic	1
Traditional Healers	WHO Orientation Workshop	15
Health Journalists	WHO Orientation Workshop	2
Military Officers	WHO Orientation Workshop	8
Total		**26**

It would be important to extend the information, education and training sessions to other non health workers including the police, members of the National Drug Law Enforcement Agency, Association of Health Journalists, community leaders and also to cover a number of issues related to the stigmatization, discrimination and human rights violations directed towards people with mental illness.

6. Availability of Psychotropic Medications

There is a National Drug Policy in The Gambia, which was formulated for the period covering 1994-2000. In addition the National Essential Drug List, was last revised in 2005. The Central Medical Review Board periodically reviews this essential drug list.

Drug procurement and distribution is the responsibility of the DOSH. The transportation of medicines and procurement is handled by the Central Medical Stores. There are ongoing difficulties in both the procurement and distribution of medications (both psychotropic and general medications). These difficulties arise both as a consequence of insufficiencies, transport and supply/production problems at supplier (international) level as well as local levels.

Major issues that must be addressed in relation to psychotropic medications including the following:

1. Inconsistent availability of psychotropic medications at the secondary and tertiary care levels. This includes availability of medications such as benztropine (cogentin), which are **essential for patient safety**.
2. Revision of the list of purchased psychotropic medications. Many psychotropic medications are currently available in generic form. Purchase of newer generic medications may be cost-effective and may provide safer treatment options for patients (i.e., generic fluoxetine)
3. Quantities of medicines are not sufficient to cater for the number of people suffering from mental disorders and requiring medication dues to lack of available funds
4. Non availability of some essential psychotropic medications at the primary care level.
5. The lack of fuel and available transport to take drugs from central stores into the provinces in time

The following table summarizes the availability of psychotropic medications in the Gambia at the primary, secondary, and tertiary care level for the major services.

Table 8: Availability of psychotropic medications in the Gambia at different service levels

Psychotropic Medication	Generic Drug Purchased	Belong to the National EDL	Minor health centres	Major health centres	Hospital and Campama
Anti-convulsants:					
Carbamazepine	✓	✓	IS	IS	CS
Ethosuximide			*NA*	*NA*	CS
Phenobarbital		✓	IS	IS	CS
Phenytoin sodium		✓	CS	IS	CS
Sodium Vlproate			*NA*	*NA*	*NA*
Lamotrigine			*NA*	*NA*	*NA*
Topiramate			*NA*	*NA*	*NA*
Gabapentin			*NA*	*NA*	IS
Mood Stabilizers					
Lithium Carbonate			*NA*	*NA*	*NA*
Anti-psychotics					
Chlorpromazine PO		✓	CS	CS	CS
Chlorpromazine IM		✓	IS	IS	CS
Fluphenazine IM		✓	*NA*	IS	CS
Haloperidol PO		✓	IS	CS	CS
Haloperidol IM		✓	IS	CS?	CS
Haloperidol Depot		✓	*NA*	*NA*	IS
Piportil Depot			*NA*	*NA*	*NA*
Flupenthixol Depot			*NA*	*NA*	?
Trifluperizine PO			*NA*	IS	CS
Thioridazine PO			IS	CS	CS
Atypical anti-psychotics					
Clozapine			*NA*	*NA*	*NA*
Risperidone			*NA*	*NA*	IS*
Olanzapine			*NA*	*NA*	*NA*
Quetiapine			*NA*	*NA*	*NA*
Benzo-diazepines:					
Lorazepam PO			*NA*	*NA*	*NA*
Lorazepam IM			*NA*	*NA*	*NA*
Diazepam PO		✓	*NA*	CS	CS
Diazepam IM		✓	IS	CS	CS
Clonazepam			*NA*	*NA*	*NA*
Stimulants					
Ritalin			*NA*	*NA*	*NA*
Dexedrine			*NA*	*NA*	*NA*

Anti-depressants					
Imiprimine			IS	IS	CS
Clomipramine			*NA*	*NA*	*NA*
Amitriptyline		✓	IS	IS/CS	CS
Paroxetine			*NA*	NA	IS*
Sertraline			*NA*	NA	IS*
Fluoxetine			*NA*	IS	IS*
Citalopram			*NA*	*NA*	*NA*
Antiparkinson Drugs					
Benztropine PO			*NA*	*NA*	IS
Benztropine IM			*NA*	*NA*	IS
Biperiden PO			*NA*	*NA*	IS
Biperiden IM			*NA*	*NA*	IS
Levodopa			*NA*	*NA*	IS*
Carbidopa/levodopa			*NA*	*NA*	IS*
Amantadine			*NA*	*NA*	IS*

CS. Consistent Supply
IS: Inconsistent Supply
NA: Not Available
Belong to the WHO Model List of Essential Medicines (revised March 2005). See annex 8:
All drugs listed in table belong to the national formulary

7. Mental Health Information Systems

Currently, the mental health service information is not adequately incorporated into the general Health Management Information System (HMIS). Demographic data and diagnostic information of patients is available from the Polyclinic at RVTH, and Campama Psychiatric Unit. In addition, Campama psychiatric Unit keeps a record of patient data pertaining to admission and discharge. This information is collated and available centrally.

Although demographic, general health and basic mental health (case identification) information is collected at the level of the health center facilities, mental health data included in the data sets of the Health Management Information System (HMIS) only indicates whether the patient has a mental or neurological problem. The Table below summarizes the data which is collected from different levels of the system.

Table 9: Types of Mental Health data available from Patient Records and Mental Health Services / Health Centre Facilities

Information collected or available	Available from Health Centres (major and minor facilities)		Available from Polyclinic at RVTH		Available from Campama Psychiatric Unit	
	YES	NO	YES	NO	YES	NO
Geography	✓		✓		✓	
Age	✓		✓		✓	
Sex	✓		✓		✓	
Marital status	✓		✓		✓	
Socio-economic status						
# New MH patients			✓		✓	
# of return MH patients			✓		✓	
Total # of MH patients	✓		✓		✓	
MH case identification using Patients informal, broad categories of 'mental disturbance'	✓					
Diagnosis made based on DSM or ICD criteria			✓		✓	
Length of service use					✓	
Treatment			✓		✓	
Mortality						
Suicide					✓	
Serious adverse Side Effects to medications						
Other adverse events						

➲ General Health Management Information System (HMIS)

Information is collected, gathered from the different levels of services and is available centrally:

➥ **Hospital level**:

The Polyclinic, Community Mental Health Team and Campama Psychiatric Unit collect demographic and clinical/treatment information (see table §.vi) that is centrally processed to the director of Health Services through the RVTH Records Office and the RVTH Management (paper copies only). Then the director of Health Services will redirect the information to the HMIS.

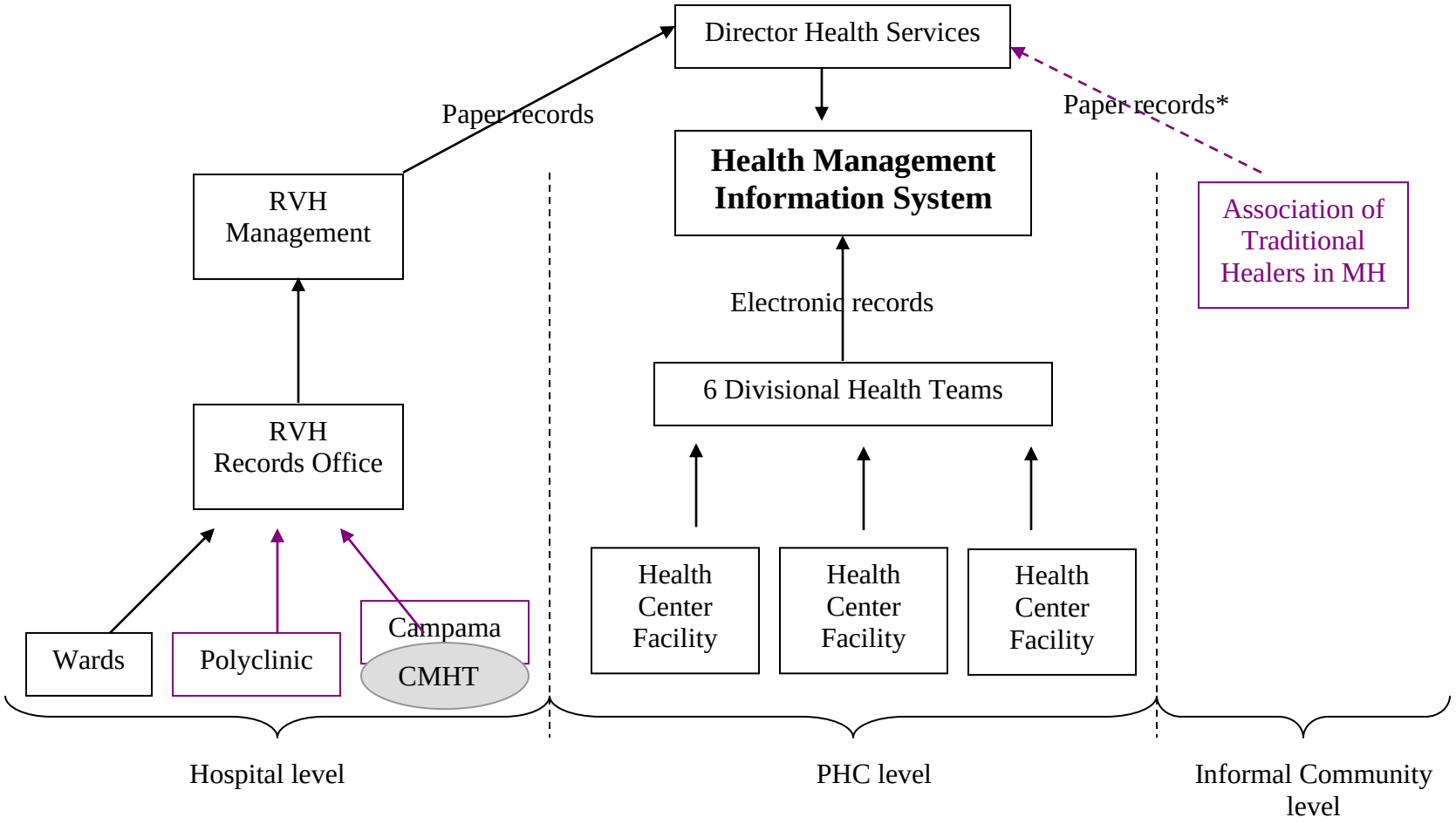
➥ **Health Centre level** (both major and minor facilities):

General information is collected for each patient and gathered by the relevant Health Divisional Team, that transfers it electronically and directly to the HMIS.

➥ **Informal Community level**:

Currently only the number of patients seen on consultations, treated and kept at the traditional healers' home is registered. A more detailed form may be developed in the future. Traditional healers say that they do not have enough time to fill such forms.

Figure 5: Reporting structure of the General Health Management Information System (HMIS)



8. Mental Health Policy and Legislation

The Gambia has no specific national mental health policy, however, mental health is mentioned as a health program area as part of the 'Changing for Good' health policy (2002). ***The Mental Health Legislation in The Gambia, is seriously outdated and inadequate. The current mental health legislation was enacted in 1942 and is called the*** **Suspected Lunatic Act.** ***The last revision of this legislation was performed in 1964.*** It does not have any provisions to protect patients against involuntary admission and treatment nor any requirement for consent to admission, treatment or subsequent review of continued treatment. In addition the legislation does not address:

1. Access to Care
2. Protection of Rights of People with Mental Disorders
3. Rights of Families and Carers
4. Quality Assurance
5. Psychotropic Medications
6. Protection of the Rights of Vulnerable Groups
7. Substance Use
8. Legislative Links with Other Sectors

9. Financial resources and Budget for Mental Health

General Health Care in The Gambia is funded through a 'global health budget'. The total budget for health in 2005 was 235 million dollars. There is no separate budget line for mental health. The budget for mental health care spending is embedded within this general health care budget. The entire allocated budget is for salaries, allowances and procurement of office materials at National level. Some funds are provided for the running of the RVTH polyclinic and for running Campama psychiatric Unit and for providing a basic supply of psychotropic medicines). Information regarding the percentage of the **overall health budget** spent on mental health is not available.

Financing of mental health services is provided through out-of pocket payments, private insurance, non-profit organizations, grants (WHO) and minimally through general taxation.

See diagram below:

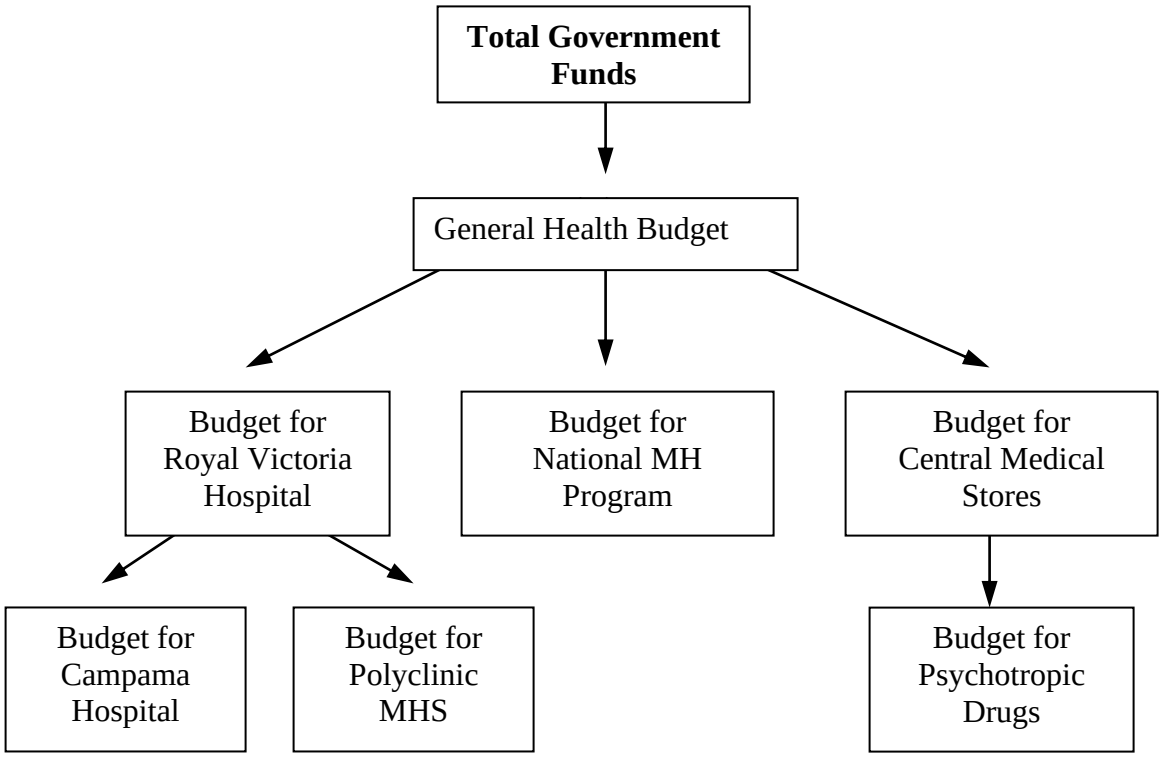


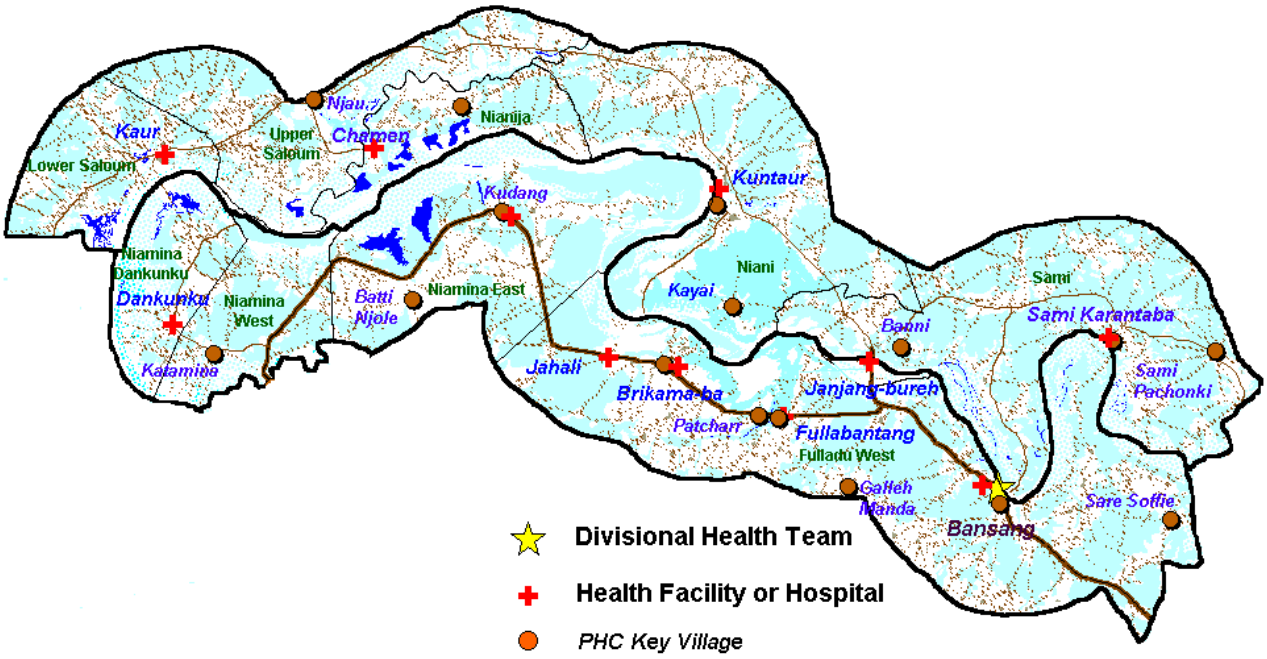
Figure 6: Source and allocation of budget to different mental health sectors

Annex 3
MAPS OF GENERAL & MENTAL HEALTH SERVICES IN THE GAMBIA

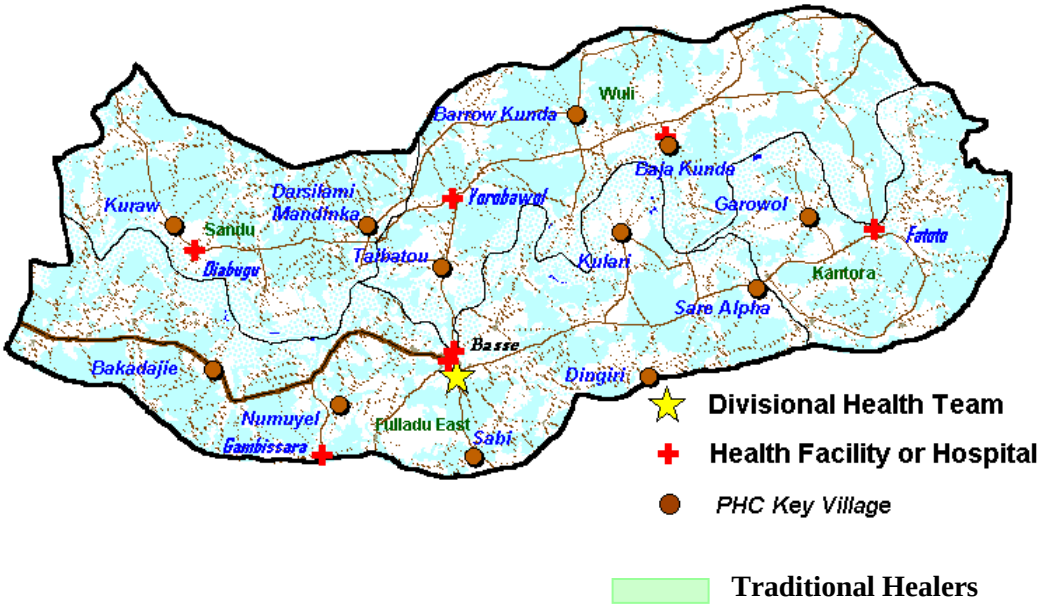
Map 1: The Gambia

Please, refer to the detail maps of the six divisions showing the Divisional Health Teams, Traditional healers Primary Health Care Key Villages and Health posts, centers and hospitals as distributed within in the country below.

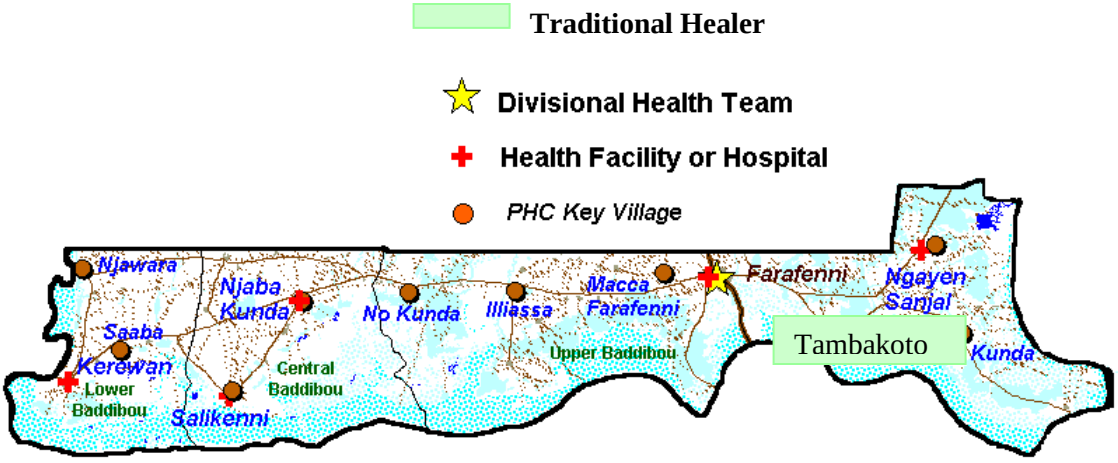
Map 2: Central River Division



Map 3: Upper River Division

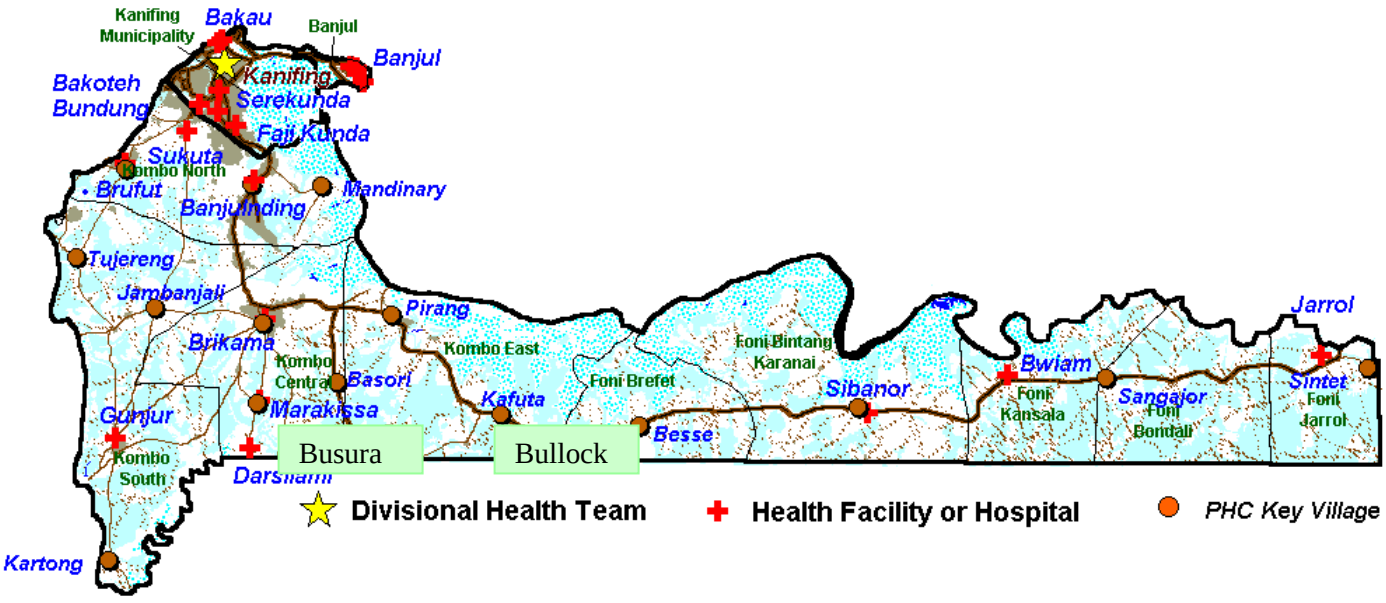


Map 4: North Bank Division-East

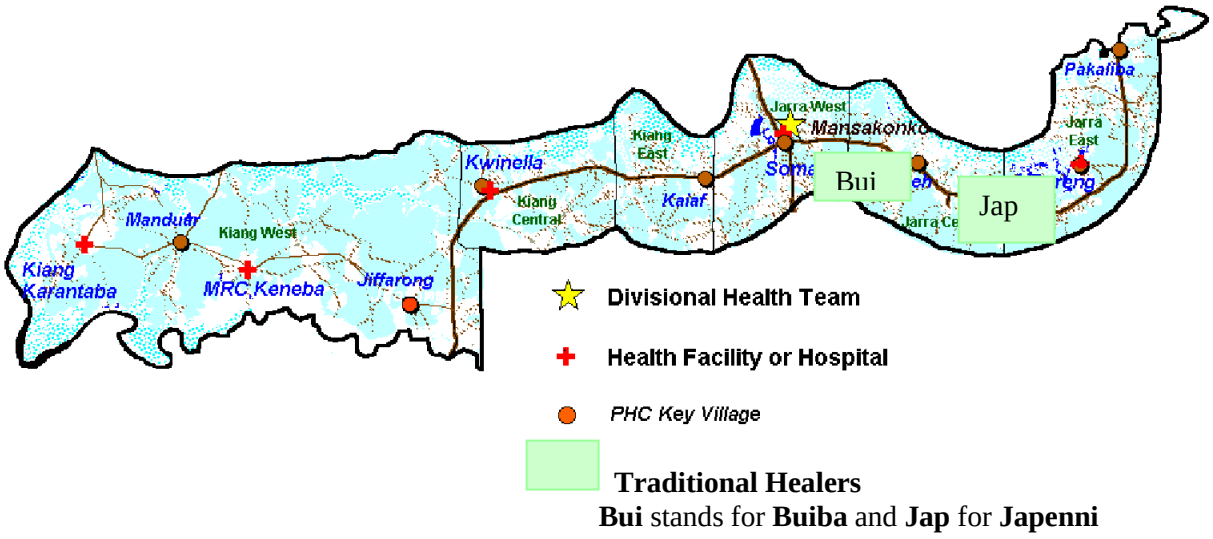


Map 5: North Bank Division-Western

Map 6: Western Division



Map 7: Lower River Division



Bui stands for **Buiba** and **Jap** for **Japenni**

Annex 4:
ROLES & RESPONSIBILITIES OF THE MAIN SECTORS

Table: Roles & Responsibilities of the main sectors in the Gambia

MAIN SECTORS	ROLES & RESPONSIBILITIES
Department of State for Health and social welfare	➢ The Department of State for Health and Social Welfare has the final responsibility for the organization and provision of mental health services in the country. ➢ The department is responsible for policy infrastructure, staffing programme formulation, implementation and the general coordination and administration of the services. The appointment of a national mental health coordinator and the broadening of the mental health-coordinating group will be useful developments in this regard. ➢ Other institutes such as the Gambia College and the University of the Gambia should contribute and formulate training programmes that are consonant with the present health needs of the country.
Department of State for Finance	➢ Provide funds for implementation of mental health policy and action plan
Department of State for Education	➢ Include Mental Health as an integral part of the Education policy ➢ Jointly work with the Department of State for Health and Social Welfare and other educational institutions to better inform teachers about mental health problems, including substance abuse, school based promotion and prevention programmes which can be implemented as well as agencies and services to which children can be referred
Directorate of Social Welfare	➢ Include Mental Health as an integral part of the Social Welfare Policy. ➢ Identify social causes of stress and take action to reduce them. ➢ Adopt social measures in order to protect people with mental disorders and help them to maintain links with their families, whether they are hospitalised or not. ➢ Develop an interest in preserving patients' employment and also to assist in finding employment for patients. ➢ Participate in public health education, addressing stigma and social aspects of mental illness, causation and effects
Department of State for Interior	➢ Train and encourage police officers and prison staff to early identify and refer people with mental disorders. ➢ Include mental health in the training of security forces ➢ Develop Mental Health Prevention in prisons, avoiding prisoners' mistreatment (mockery, etc) and being aware of human emotional

	problems faced by prisoners. ➢ Mental health issues must be considered in the administration of justice, qualified mental health expert being requested to provide expert advice on the accused person
Department of State for Trade, Industry and Employment	➢ Develop and deliver mental health promotion and prevention programmes in the workplace. ➢ Include Mental Health as an integral part of the Employment/Labour Policy ➢ Work to end discrimination against people with mental disorders in the workplace
Academic Institutions	➢ The Department of State for Health through the Office of the Mental Health Coordinator will collaborate with the academic institutions and will be responsible and accountable for the development of a training module in mental health and in the training of all health cadres, periodically reviewing this input, and making available specialized and post graduate training for existing staff. ➢ They will include mental health in the training of other key public agents (e.g. teachers, security officers, social workers, community development workers, etc). ➢ Should cultivate holistic approach to health during the training of health workers. ➢ Broaden the scope of mental health from the traditional description of mental disorders to a modern concept of mental health. ➢ Should emphasize community and team approach in the prevention and promotion of mental health. ➢ The curriculum should incorporate knowledge and skills in psychotropic drug dispensing. ➢ Encourage behavioral approach in the treatment and management of mental ill health. ➢ Finally, they will be responsible for ensuring health system research in mental health.
Private Sector and professional associations	➢ The business community, private agencies and firms can help and support the government of the Gambia with fundraising. ➢ They can support some specific projects for mental health promotion and education. Funds can also go towards the setting up of mental heath services, for example, in general hospital settings. They will work in collaboration with health and social workers in order to improve the living and work conditions of people with mental disorders, supporting their socio-professional rehabilitation
Community leaders *(e.g. chiefs, commissioners)*	➢ Be involved in mental health work and in the plight of discharged patients.

	➢ Ac as advocate for mental health education and the promotion of attitude change. ➢ Protect dependents and the property of people admitted to hospitals. ➢ Monitor the work of traditional healers and provide information and support to protect their clients. ➢ Encourage community involvement in mental health work.
Traditional/Religious Healers	➢ Traditional/Religious Healers should be encouraged to be members of the mental health association, to participate in various workshops on mental health and to work in close collaboration with formal mental health services, particularly at primary and community levels. ➢ They are responsible for early referral of any people with mental disorders that they have identified. ➢ While appreciating those traditional practices are enshrined within the local tradition they should also be aware that some of their practices can induce stress and cause family disruption. ➢ Should encourage discharged patients to take prescribed treatment. ➢ Help change community attitudes and social stigma attached to people with mental disorders.
Consumer and Family Groups	➢ Advocacy ➢ Involvement in Organization of Services ➢ Involvement in the Drafting and implementation of Legislation ➢ Involvement in the drafting and implementing Policy
NGOs and CBOs)	➢ Non Governmental Organizations, working in collaboration with health workers, will be responsible and accountable for: ➢ Assisting in the formulation and implementation of mental health policy ➢ Promoting positive attitudes towards mental health work. ➢ Educating and sensitizing communities on mental health issues. ➢ Identifying and referring people with mental disorders to appropriate health facilities. ➢ Supporting people (including children and adolescents) with mental disorders and their families and facilitating their rehabilitation in the community ➢ Setting up projects that will benefit mental patients and mobilizing resources for specific mental health programmes.
Police/security officers	➢ Identification and early referral of patients with mental disorders. ➢ Respond to psychiatric emergencies e.g. violence – not to treat every

	body as a criminal. ➢ Be able to give first AID treatment. ➢ Divert people with mental disorders to the health system rather than charging them. ➢ Record observations and be able to provide a history when referring people with suspected mental disorders. ➢ Help prevent alcohol and substance abuse. ➢ Know and implement the provisions of the upcoming mental health act.
Social workers	➢ Identify social causes of stress and alleviate them. ➢ Identify and refer patients with mental disorders. ➢ Maintain links with families of all people with mental disorders in and out of hospital. ➢ Follow-up defaulters and identify reasons for defaulting. ➢ Develop an interest in preserving patient's employment and also to assist in finding employment for patients. ➢ Participate in public health education, addressing stigma and social aspects of mental disorders, causation and effects. ➢ Liaise with health workers especially the CMHN and also do case work. ➢ Do family/home visits.
School Teachers	➢ Identify and refer children with emotional and mental problems as well as those with learning difficulties due to mental retardation, hearing and visual problems. ➢ Identify children with bad habits e.g. alcohol/drug abuse. ➢ Participate in health education in mental health. ➢ Support children on drug treatment e.g. epileptics, ADHD. ➢ Help communities to develop positive attitudes toward people with mental disorders
Legal Professions	➢ Spearhead amendments in the law to protect and promote the rights of people with mental disorders ➢ Help in the drafting and implementation of the law ➢ Seek assessment for people with suspected mental disorders early in the judicial process and divert from the criminal justice system where possible. ➢ Take into account the presence of a mental disorder in the administration of justice
Local Government	➢ To build rehabilitation centers in their communities. ➢ Streamline the law to make area councils responsible for providing

	rehabilitation facilities for people with mental disorders. ➢ Stimulate the community to mental health work and in the change of attitude towards people with mental disorders. ➢ Provide treatment and follow-up services. ➢ Transport patients to and from treatment centers for check-ups, appointments and admissions where necessary ➢ Care for destitute people with mental disorders.
Media	➢ Help with public mental health education and information campaigns for mental disorders, alcohol and substance abuse. ➢ Advocacy campaigns to fight stigma and discrimination towards people with mental ➢ Host local programmes and allow air-time and space for mental health issues on the media.
Prisons	➢ Identify and refer early, people with disorders in the prisons. ➢ Always remember that the prison is a stressful place and be aware of human emotional problems that prisoners (inmates) may face. ➢ Separate prisoners with mental disorders from others to prevent abuse and mockery ➢ Increase awareness of mental health issues in the prisons including those, which can cause psychological problems e.g. mockery etc. ➢ Supervise those taking medicines and make due they keep appointments.
Youth and Probation Officers	➢ Identify and refer youth with mental disorders and other emotional problems ➢ Teach the dangers of alcohol/drug abuse, and other related problems ➢ Liaise with CMHN and other health workers on mental health education and community stimulation in mental health work. ➢ Assist in rehabilitation of youths with emotional problems. ➢ Assist to find suitable jobs and vocational training for the youth with past history of mental disorders.
Agricultural Extension Workers	➢ Assist in rehabilitating people with mental disorders and teach them the necessary skills to be productive members of society. ➢ Assist people with mental disorders to benefit from existing economic schemes e.g. small scale gardening / community garden projects. ➢ Liaise with the health workers, social welfare officers etc as part of multidisciplinary rehabilitation team ➢ Identify and refer patients with mental disorders.
Employers	➢ Be sensitive to the psychological needs of their work force.

	➢ Identify and refer those workers with mental health problems. ➢ Support discharged patients and look at mental disorders like other physical illness. ➢ Give patients permission to keep up with appointment for check-ups. ➢ Take interest in employer problems and give support e.g. alcohol/drug problems. ➢ Know the danger of alcohol and drugs in the employment situation. ➢ Be aware that low productivity and absenteeism could be a sign of mental disorder. ➢ Take into consideration all aspects of health including the psychological ones when dealing with compensation issues of employees.
Mental Health Associations	➢ Advocate to promote mental health at work. ➢ Assist in educating the community on mental health issues. ➢ Assist in and advocate for the review and implementation of mental health policy. ➢ Identify and refer individuals and families to appropriate treatment centres ➢ Mobilize resources for specific mental health programmes. ➢ Set up projects which will benefit people with mental disorders ➢ Assist in fund raising for long-term rehabilitation programmes. ➢ Help fight the stigma and discrimination towards people with mental disorders
Faith based organizations	➢ Identify, support and assist people and families with mental disorders, social and psychological problems. ➢ Give support to members with such problems. ➢ Assist in rehabilitation. ➢ Assist in counseling of people with mental disorders. .
Red Cross	➢ Sensitize the community on mental health issues. ➢ Render mental health aid in emergency situations. ➢ Help integrate mental health during workshops and seminars. ➢ Identify and refer those with mental health problems. ➢ Support fund raising activities to finance rehabilitation programmes.
Business Community /Agencies & Firms	➢ Help with fund raising. ➢ Support specific projects.

	➢ Assist destitute mental patients. ➢ Support public health education.
Alcohol Anonymous (AA groups)	➢ Help with identification and referral of alcoholics. ➢ Support and encourage people who want to stop drinking ➢ Help with counseling problem drinkers ➢ Assist with health education on dangers of alcohol and drugs. ➢ Liaise with mental health team and other health workers on mental health. ➢ Promote family support

Annex 5
ROLES & RESPONSIBILITIES OF HEALTH WORKERS WITHIN THE DIFFERENT LEVELS OF HEALTH SERVICES

Some of the problems that the mental health service is facing stem from a lack of coordination. In part this is due to blurred functions, responsibilities and roles in mental health for various categories of workers. The table below identifies clear roles and responsibilities for work in mental health.

Table: Roles and Responsibilities of health workers within the different levels of health services

HEALTH WORKERS	ROLES & RESPONSIBILITIES
KEY PRIMARY HEALTH CARE VILLAGES & MINOR HEALTH CENTRES	
Village Health Workers *at key primary health care villages*	➢ Shall respond to mental health emergencies by prompt referral for treatment to a higher level. ➢ Identify people with mental disorders in the community, initiate simple management and refer them to the next level e.g. epileptics, alcohol/drug abuser, mental retardation etc. ➢ Follow-up all patients on psychiatric treatment and keep their records. ➢ Utilize village development committee and village health committee, "kafos" and youth clubs in carrying out health education in mental health e.g. alcohol/drug abuse, growth and development in children, puerperal psychosis etc.
Community Health Nurses *at key primary health care villages*	➢ Should be sensitive to mental health issues in their daily work. ➢ Identify and refer patients with mental disorders and those at greater risk of developing such disorder e.g. the elderly, pregnant women, alcoholics etc. ➢ Shall supervise and support village health workers. ➢ Collaborate with psychiatric nurses in follow-up of patients. ➢ Encourage and support community participation in mental health work.
Nurses *(State enrolled nurses and state registered nurses) at minor health centers*	➢ Shall support and supervise community health nurses. ➢ Initiate treatment for mental health emergencies and manage all other cases, referring to the next level only when necessary. ➢ Relate public education to mental health e.g. importance of ANC, immunization, nutrition, hygiene to good mental health. ➢ Collaborate with community leaders, social welfare officers and

	extension worker in promotion of good mental health. ➢ Ensure availability of essential psychotropic drugs at their stations. ➢ Identify patients in whom psychiatric symptoms may be due to underlying psychosocial factors or psychic conditions, during screening and admission. Keep proper statistics at the clinic and in their catchment area.
DIVISIONAL MENTAL HEALTH TEAM, HEALTH CENTRES & GENERAL HOSPITALS	
Medical Officers	➢ The medical officer should be sensitive to mental health issues of their patients drug their daily work. ➢ They should identify, treat or refer mental patients especially the priority disorders mentioned above. ➢ They should support and supervise staff in their catchment area and encourage them to look at mental health, as part of their work. ➢ They should liaise with psychiatric nurses on patients requiring more specialized psychiatric treatment ➢ They should assist psychiatric nurses in physical assessment of mental patients referred to them. ➢ Medical officers in minor, major facilities and in general hospitals should admit psychiatric patients for treatment similar to patients with physical disorders without any form of discrimination. ➢ They should actively participate in mental health education and in stimulating the community in the promotion of good mental health.
Divisional Health Officers *(DHOs) and focal point for mental health in the DHT*	➢ The DHO and the mental health focal point should coordinate and supervise health activities including mental health within the division ➢ Where possible, the DHO and the focal point for mental health in the DHT and mental health providers (nurses, doctors, and community workers) should synchronize their outreach services so as to maximize their returns in follow-up patients and in mental health education. ➢ The DHT should provide transport for mental health out-reach services. ➢ The DHO/focal point for mental health in the DHT should ensure that sufficient stocks of recommended psychotropic medications are available at all the village clinics, and health facilities in their jurisdiction.
Community Mental Health Nurses – *to be trained and deployed to the divisional health teams in order to eventually become the mental health focal points described above*	➢ The community mental health nurses (CMHN) is the specialist in mental health in the catchment area. ➢ The CMHN should co-ordinate all activities of the programme in the catchment area ➢ Liaise with other government department e.g. police, social workers, community workers etc. in the prevention of mental illness and in promotion of good mental health in her/his catchment area.

	➢ Involve the family, as much as possible, in the treatment of patients and clearly explain family's responsibilities in the after-care of the patients. ➢ Introduce, utilize and encourage the use of appropriate techniques for the treatment of patients with psychological problems. ➢ Encourage a meaningful up and down referral system. ➢ Consult with the psychiatrist and other specialists in her/his daily work, as appropriate. ➢ Liaise with medial officers and general nurses in the physical assessment and admission of mental patients. ➢ Collect meaningful mental health statistic in her/his catchment area. ➢ Organize and participate mental health workshops as resource persons in mental health. ➢ Be actively involved in the training of health workers in mental health. ➢ Take part in research activities.
Occupational Therapists ***based in general hospitals***	➢ Occupational therapy should be seen as an integral part of treatment of people with mental disorders ➢ The occupational therapist should take a leading role in the early rehabilitation of patients both in the hospital and within the community. ➢ Occupational therapists should encourage the use of suitable and affordable local materials. ➢ Involve families, social workers employers etc where possible, in rehabilitation programmes. ➢ Liaise with other government Departments and NGO in developing multidisciplinary programmes. ➢ Encourage clients in appropriate recreational activities with clients consent
Psychologists ***based in general hospitals***	➢ Develop clinical psychological services in the country. ➢ Cultivate interest and skills of mental health workers in the use of psychological technique in the treatment of mental disorders ➢ Motivate and encourage other Gambians to take up clinical psychology. ➢ Conduct clinical research in mental health.
Psychiatrists ***based in general hospitals and Campama psychiatric unit***	➢ Set standard of clinical care based on modern psychiatric principles. ➢ Carry out specialized treatment of patients referred, from specialist, colleagues and other sources. ➢ Provide clinical support and guidance to staff ➢ Participate actively in teaching, training and curriculum development in mental health.

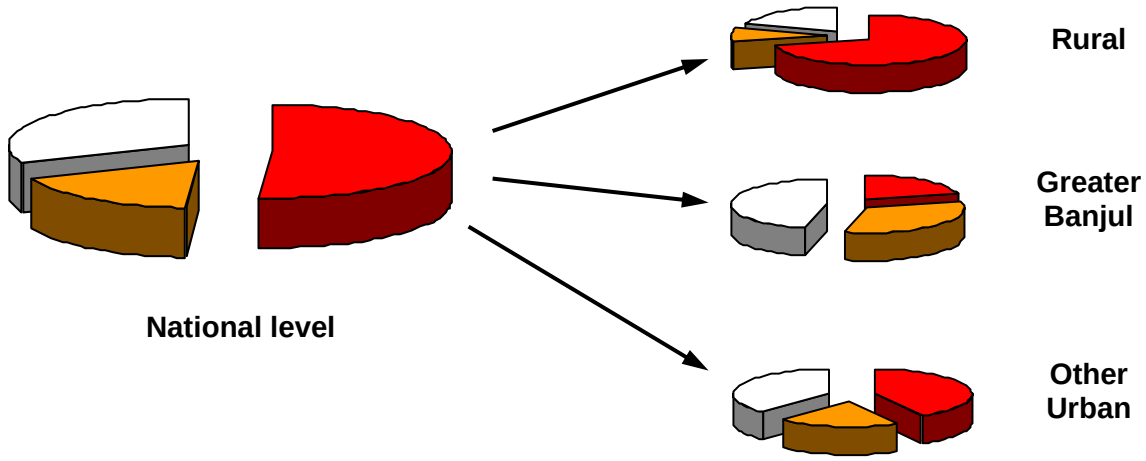
	➢ Encourage and actively participate in mental health education of the community. ➢ Assist clients in forensic work in court. ➢ Carry out research in mental health. ➢ Advise the Department of State for Health and Social Welfare on professional issues related to mental health. ➢ Other medical specialists should participate in the joint management of psychiatric patients in their field of specializing.
Hospital Management Board	➢ Shall include an expert in mental health ➢ They should develop more positive attitudes toward mental health work and give support to mental health workers based in their hospitals. ➢ Provide adequate supply of drugs, beds, linen and other items for mental health work. ➢ Ensure availability of suitable consulting rooms for proper history taking and assessment of mental patients. ➢ Ensure availability of transport for communities out-reach services ➢ Matrons should be aware that all mental health nurses in their hospitals are professionals and administratively under them! It is the responsibility of the matrons to complete appraisals as well as to make recommendations for promotion and for further training of these nurses.

Annex 6
POVERTY IN THE GAMBIA

Table: Percentage Distribution of Persons in Poverty Categories 1992 and 1998

Year / Poverty Category		National	Rural	Greater Banjul	Other Urban
1992*	Extremely poor	15%	23%	5%	9%
	Poor	18%	18%	12%	31%
	Non poor	67%	59%	83%	60%
1998**	Extremely poor	51%	71%	21%	42%
	Poor	18%	9%	33%	20%
	Non poor	31%	20%	46%	38%

Figure: Percentage Distribution of Persons in Poverty Categories in the Gambia (1998)

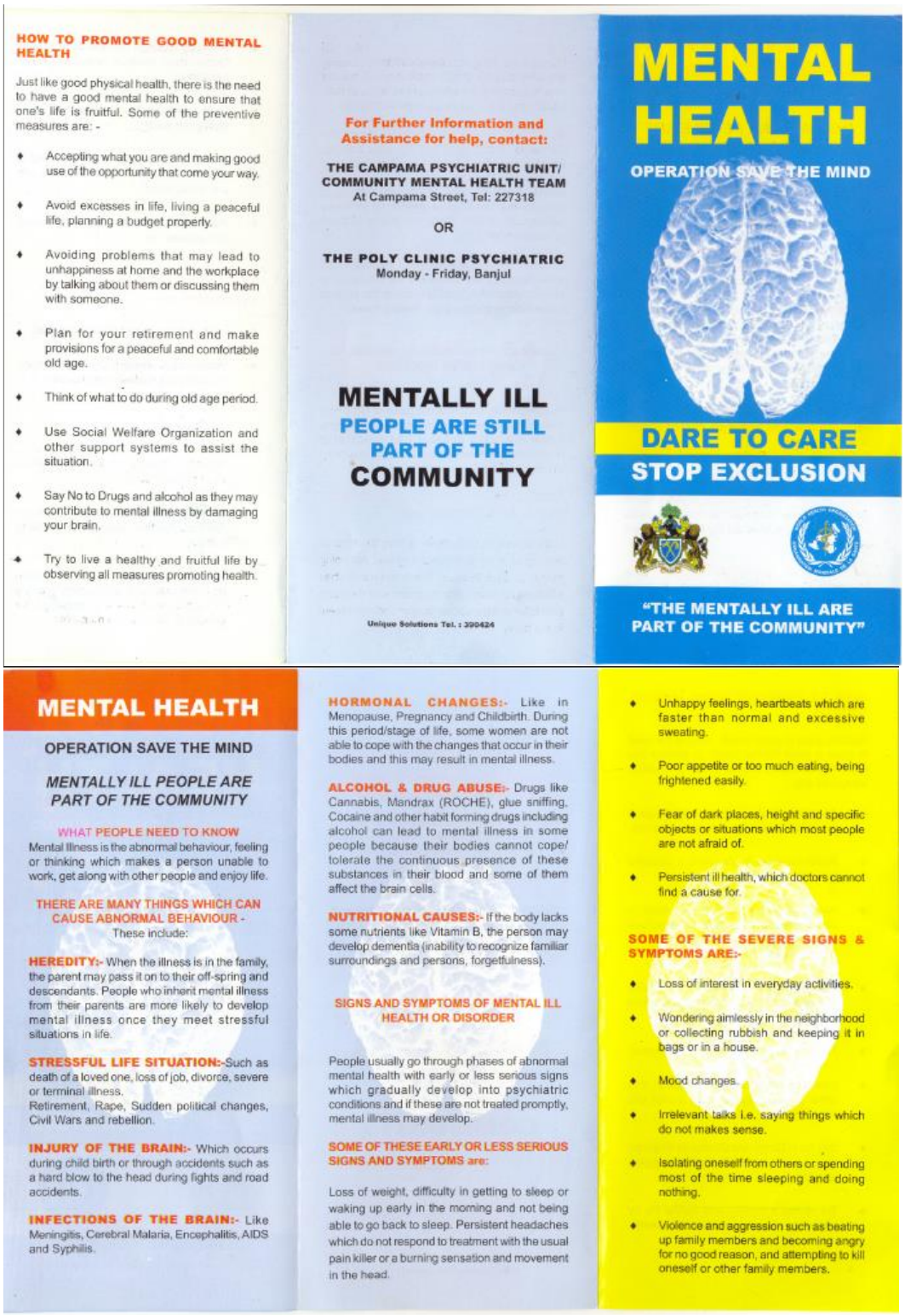


Sources:

***The Gambia 1992 Household Economic Survey**: Iqbal Ahmed, Arne Bigsten, Jorge A. Munoz, Prem Vashishtha, 1992. Poverty in the Gambia. World Bank/ILO Analytical/Working Papers; February 1992. 173 pages. Not available in electronic format.

****The Gambia 1998 National Household Poverty Survey** (funded by UNDP, with technical assistance from ILO).

Annex 7
OPERATION 'SAVE THE MIND' (Leaflet)



HOW TO PROMOTE GOOD MENTAL HEALTH

Just like good physical health, there is the need to have a good mental health to ensure that one's life is fruitful. Some of the preventive measures are: -

- Accepting what you are and making good use of the opportunity that come your way.
- Avoid excesses in life, living a peaceful life, planning a budget properly.
- Avoiding problems that may lead to unhappiness at home and the workplace by talking about them or discussing them with someone.
- Plan for your retirement and make provisions for a peaceful and comfortable old age.
- Think of what to do during old age period.
- Use Social Welfare Organization and other support systems to assist the situation.
- Say No to Drugs and alcohol as they may contribute to mental illness by damaging your brain.
- Try to live a healthy and fruitful life by observing all measures promoting health.

For Further Information and Assistance for help, contact:

THE CAMPAMA PSYCHIATRIC UNIT/ COMMUNITY MENTAL HEALTH TEAM
At Campama Street, Tel: 227318

OR

THE POLY CLINIC PSYCHIATRIC
Monday - Friday, Banjul

MENTALLY ILL PEOPLE ARE STILL PART OF THE COMMUNITY

Unique Solutions Tel. : 390424

MENTAL HEALTH

OPERATION SAVE THE MIND

DARE TO CARE

STOP EXCLUSION

"THE MENTALLY ILL ARE PART OF THE COMMUNITY"

MENTAL HEALTH

OPERATION SAVE THE MIND

MENTALLY ILL PEOPLE ARE PART OF THE COMMUNITY

WHAT PEOPLE NEED TO KNOW

Mental Illness is the abnormal behaviour, feeling or thinking which makes a person unable to work, get along with other people and enjoy life.

THERE ARE MANY THINGS WHICH CAN CAUSE ABNORMAL BEHAVIOUR -
These include:

HEREDITY:- When the illness is in the family, the parent may pass it on to their off-spring and descendants. People who inherit mental illness from their parents are more likely to develop mental illness once they meet stressful situations in life.

STRESSFUL LIFE SITUATION:-Such as death of a loved one, loss of job, divorce, severe or terminal illness.
Retirement, Rape, Sudden political changes, Civil Wars and rebellion.

INJURY OF THE BRAIN:- Which occurs during child birth or through accidents such as a hard blow to the head during fights and road accidents.

INFECTIONS OF THE BRAIN:- Like Meningitis, Cerebral Malaria, Encephalitis, AIDS and Syphilis.

HORMONAL CHANGES:- Like in Menopause, Pregnancy and Childbirth. During this period/stage of life, some women are not able to cope with the changes that occur in their bodies and this may result in mental illness.

ALCOHOL & DRUG ABUSE:- Drugs like Cannabis, Mandrax (ROCHE), glue sniffing, Cocaine and other habit forming drugs including alcohol can lead to mental illness in some people because their bodies cannot cope/ tolerate the continuous presence of these substances in their blood and some of them affect the brain cells.

NUTRITIONAL CAUSES:- If the body lacks some nutrients like Vitamin B, the person may develop dementia (inability to recognize familiar surroundings and persons, forgetfulness).

SIGNS AND SYMPTOMS OF MENTAL ILL HEALTH OR DISORDER

People usually go through phases of abnormal mental health with early or less serious signs which gradually develop into psychiatric conditions and if these are not treated promptly, mental illness may develop.

SOME OF THESE EARLY OR LESS SERIOUS SIGNS AND SYMPTOMS are:

Loss of weight, difficulty in getting to sleep or waking up early in the morning and not being able to go back to sleep. Persistent headaches which do not respond to treatment with the usual pain killer or a burning sensation and movement in the head.

- Unhappy feelings, heartbeats which are faster than normal and excessive sweating.
- Poor appetite or too much eating, being frightened easily.
- Fear of dark places, height and specific objects or situations which most people are not afraid of.
- Persistent ill health, which doctors cannot find a cause for.

SOME OF THE SEVERE SIGNS & SYMPTOMS ARE:-

- Loss of interest in everyday activities.
- Wondering aimlessly in the neighborhood or collecting rubbish and keeping it in bags or in a house.
- Mood changes.
- Irrelevant talks i.e. saying things which do not makes sense.
- Isolating oneself from others or spending most of the time sleeping and doing nothing.
- Violence and aggression such as beating up family members and becoming angry for no good reason, and attempting to kill oneself or other family members.

Annex 8
WHO LIST OF ESSENTIAL DRUGS – Medicines related to Mental Health Care

Table: WHO List of Essential Drugs - Medicines related to Mental Health Care

24. PSYCHOTHERAPEUTIC MEDICINES	
24.1 Medicines used in psychotic disorders	
Chlorpromazine	tablet, 100 mg (hydrochloride); syrup, 25 mg (hydrochloride)/5ml; injection, 25 mg (hydrochloride)/ml in 2-ml ampoule
Fluphenazine	injection, 25 mg (decanoate or enantate) in 1-ml ampoule
Haloperidol	tablet, 2 mg, 5 mg; injection, 5 mg in 1-ml ampoule
24.2 Medicines used in mood disorders	
24.2.1 Medicines used in depressive disorders	
Amitriptyline	tablet, 25 mg (hydrochloride)
24.2.2 Medicines used in bipolar disorders	
Carbamazepine	scored tablet, 100 mg, 200 mg
Lithium carbonate	capsule or tablet, 300 mg
Valproic acid	enteric coated tablet, 200 mg, 500 mg (sodium salt)
24.3 Medicines used in generalized anxiety and sleep disorders	
Diazepam	scored tablet, 2 mg, 5 mg
24.4 Medicines used for obsessive compulsive disorders and panic attacks	
Clomipramine	capsules, 10 mg, 25 mg (hydrochloride)
24.5 Medicines used in substance dependence programmes	
Complementary List	
*Methadone**	*oral solution 5 mg/5ml, 10 mg/5ml,* *concentrate for oral solution 5 mg/ml, 10 mg/ml (hydrochloride)* ** the square box is added to include buprenorphine. The medicines should only be used within an established support programme*

5. ANTICONVULSANTS/ANTIEPILEPTICS	
Carbamazepine	scored tablet, 100 mg, 200 mg
Diazepam	injection, 5 mg/ml in 2-ml ampoule (intravenous or rectal)
Magnesium sulfate*	injection, 500 mg/ml in 2-ml ampoule; 500mg/ml in 10-ml ampoule * for use in eclampsia and severe pre-eclampsia and not for other convulsant disorders.
Phenobarbital	tablet, 15-100 mg; elixir, 15 mg/5ml
Phenytoin	capsule or tablet, 25 mg, 50 mg, 100 mg (sodium salt); injection, 50 mg/ml in 5-ml vial (sodium salt)
Valproic acid	enteric coated tablet, 200 mg, 500 mg (sodium salt)
Complementary List	
Ethosuximide	capsule, 250 mg; syrup, 250 mg/5ml
9. ANTIPARKINSONISM MEDICINES	
Biperiden	tablet, 2 mg (hydrochloride); injection, 5 mg (lactate) in 1-ml ampoule
Levodopa + carbidopa	tablet, 100 mg + 10 mg; 250 mg + 25 mg

Source: Essential Medicines, WHO Model List, 14th edition (revised March 2005).