THE GAMBIA

Work to develop a mental health policy and plan for the Gambia began in 2004 with a request to WHO for information, resources and technical assistance. In 2005, the Gambia established a policy drafting committee, produced a first draft of the policy and held a number of initial consultations with many different experts, health professionals and key individuals from different government sectors within the Gambia.

The policy and plan went through a series of revisions and elaborations over a period of two years before being finalised in December 2006. Both the policy and the plan were driven by an objective assessment of the mental health situation and feedback from ongoing consultations which highlighted the great need, willingness and strategies required to strengthen the overall mental health system in order to provide effective treatment and care to those in need as well as to promote the mental health of all Gambians. In fact it is through this consultation and the work of the drafting committee that the Gambia was so effectively able to develop consensus around the future of mental health services, treatment and care and formulate its first mental health policy and strategic plan for the country.

Throughout this process, WHO worked alongside the Gambia by helping to carry out the situational assessment of mental health in the country, organize and convene a number of technical workshops, and comment and contribute to the different drafts of the policy and plan.

The official adoption of the policy and plan is expected shortly, but in the mean time a key action to fulfill the mental health plan has already been taken - the creation of the position of mental health coordinator in the Gambia and the official appointment of Mr Bakary Sonko to this position.

The vision of the mental health policy is:

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.
The key objectives of the policy are stated as follows:

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.

Twelve key strategies have been defined each with defined activities, timeframes and budget for each strategy.

- **Strategy 1**: To strengthen the national mental health coordinating unit at the Department of State for Health

- **Strategy 2**: To mobilise resources for mental health interventions with a view to providing quality services.

- **Strategy 3**: To review the existing mental health legislation of The Gambia in line with the international human rights standards.

- **Strategy 4**: To raise awareness and reduce negative perceptions about those suffering from mental and substance abuse disorders through the use of advocacy and Information, Education and Communication (IEC) strategies.

- **Strategy 5**: To improve the availability, distribution and use of cost-effective psychotropic medicines.
BEST PRACTICES - WHO African Region

- **Strategy 6**: To support the strengthening of the health management information system to adequately address mental health issues.

- **Strategy 7**: To strengthen community involvement and participation in mental health care delivery.

- **Strategy 8**: To create 3 in-patient mental health units and outpatient clinics integrated in the general hospitals.

- **Strategy 9**: To improve treatment and human rights conditions in the Campama psychiatric unit until it is closed.

- **Strategy 10**: To recruit and train a sufficient number of health workers at the specialised, community and primary health care levels in order for them to be able to provide appropriate quality mental health care at all levels.

- **Strategy 11**: To train and support traditional healers in mental health.

- **Strategy 12**: To regularly monitor and evaluate the mental health policy and plan.

for more information, see The Gambia country page

BEST PRACTICES - Mental health services: Primary health care

**BOTSWANA**

Psychiatric nurses based in secondary -level district hospitals oversee a number of primary health care clinics in each district. They visit these clinics regularly and meet with primary health care workers who have identified vulnerable cases within the community (Ben-Tovim, 1987).

References

TANZANIA

Rural dispensaries are provided by public, private, and voluntary sources. These facilities provide basic medical services in rural regions (Ahmed et al., 1996). In some rural areas, agricultural rehabilitation villages provide sheltered employment, continuous contact with local community members, and ongoing psychosocial support from traditional healers, community health workers, and GPs. These community-based services provide an alternative to hospital inpatient services for long-term and medium term patients (Kilonzo & Simmons, 1998).

References

ETHIOPIA

The services at the tertiary level have collaboratively developed a programme of mental health care at the secondary level by training psychiatric nurses. Twenty-seven regional hospitals and one health centre have opened psychiatric units, each operated by two psychiatric nurses (Alem et al., 1999).

References
TANZANIA

Community mental health care teams have been established in secondary-level clinics in the capital city but there are no such teams in rural areas. In both rural and urban areas, secondary-level facilities are located in psychiatric units in district general hospitals (Kilonzo & Simmons, 1998).

References

GHANA

Protecting rights through mental health legislation in Ghana

Ghana, in collaboration with WHO, has recently developed a new Mental Health Bill to replace its previous outdated 1972 law. This outdated law strongly emphasized institutional care to the detriment of providing mental health care in primary health care settings, contrary to both national and international policy directives.

Furthermore, procedures for involuntary admission in the 1972 law did not sufficiently protect people against unnecessary admission. Indeed, serious mistreatments of people with mental disorders - some have been involuntarily locked away in institutions for decades – have persisted under this legislation.

It is in this context that Ghana requested the support of WHO in order to draft and implement new mental health legislation to promote best practice in treatment and care and to protect the human rights of people with mental disorders.

Through a series of training workshops, broad consultations with key national stakeholders, and ongoing critical analyses and reviews of the different drafts of the new law using WHO materials and tools, Ghana has developed a comprehensive Mental Health Bill which protects the rights of people with mental disorders and promotes
BEST PRACTICES - WHO African Region

mental health care in the community in accordance with international human rights standards.

Specifically, the new Bill aims to:

- Improve access to in-patient and out-patient mental health care in the communities in which people live
- Regulate mental health practitioners in both the public and private sectors
- Combat discrimination and stigmatization and promote human rights
- Promote voluntary treatment and, if necessary, voluntary admission to mental health facilities.
- Introduce safeguards to protect against arbitrary and unjustified involuntary admission and treatment

WHO is helping Ghana to prepare for the implementation of the new legislation, and has provided guidance on the elaboration of a detailed action plan and regulations for putting the provisions of the law into effect.

Ghana's Mental Health Bill has gained the support of doctors, nurses and traditional healers and can serve as a model for other African countries wishing to develop progressive mental health laws that respect international human rights standards.


SOUTH AFRICA

Mental Health Law Reform In South Africa.

Soon after democratic rule was established in South Africa 1994, a law reform process was initiated to remove all discriminatory legislation and ensure that all laws were in line with the new human rights constitution of the country and international human rights standards. One of the laws identified as being in urgent need of reform was the Mental Health Act of 1973.

This law embodied a custodial approach to mental disorder and had not only dismally failed to protect a range of human rights that people with mental disability are entitled to, but was itself responsible for certain abuses of human rights. A number of investigations had in fact found serious human rights violations in a range of psychiatric institutions.

The reform process started in 1998 with a notification to a range of key stakeholders (eg. user groups, service providers, professional organizations, NGOs) that the Minister of
Health was embarking on mental health law reform. A “package” with relevant information was compiled and sent to the identified stakeholders. This included important WHO and UN documents (such as the MI Principles, Mental Health Care Law), laws from other countries, key articles that that been written in South Africa about mental health law, recommendations on mental health service changes from a Ministerial Committee on mental health, inputs received by the ministry from groups of human rights activists and a section on mental health from a “White paper” for the Transformation of the Health System in South Africa which summarized agreed upon mental health policy for the country. These stakeholders were requested to peruse these documents, draw on their own experiences and send detailed comments on what they would like to see included in new mental health legislation. A large number of comments and recommendations were received. From these comments and from an understanding of the objectives of the government for mental health reform, a first draft of the new proposed legislation was drafted. This draft was then sent to a much wider constituency and was made open for public comment. Individual meeting were held with stakeholders and joint meetings where people with different points of view could debate issues, were held. Provinces (there are nine in South Africa) also had hearings and provided inputs. In particular the limitations of certain provinces to implement “ideal” legislation due to resource constraints was provided. This led to sometimes innovative changes, for example the establishment of a category of a “mental health care practitioner” who could conduct mental health examinations with regard to assisted and involuntary admission. A legal drafter assisted with translating all the inputs into “legal language” - though a particular objective was to keep the language as user friendly as possible.

When the Bill was submitted to parliament, the portfolio committee on health advertised widely, including through the press, that it would be holding public hearings on the proposed new legislation. A number of constituents provided inputs at these hearings.

The Mental Health Care Act (Act 17 of 2002) was approved by Parliament in 2002. Regulations were then drawn up and the Act came into force in 2005. Extensive training has been required to ensure that all relevant constituencies are aware of the contents of the legislation and how to enact the provisions.

**Mental Health Care Act (Act 17 of 2002) – Republic of South Africa**

The objects of the Act (Article 3) are to:

- Regulate mental health care in a manner that:
  1. makes the best possible mental health care, treatment and rehabilitation available to the population equitably, efficiently and in the best interests of mental health users within the limits of the available resources,
  2. co-ordinates access to mental health care, treatment and rehabilitation services to various categories of mental health care users, and
  3. integrates the provision of mental health care services into the general health services environment;
- Regulate access to and provide mental health care, treatment and rehabilitation to:
  - (1) Voluntary, assisted and involuntary mental health care users,
  - (2) State patients (mentally ill offenders),
  - (3) Mentally ill prisoners;
- Clarify the rights and obligations of mental health care users and the obligations of mental health care providers;
- Regulate the manner in which the property of persons with mental illness and persons with severe and profound intellectual disability may be dealt with by a court of law.

**Provision of mental health care, treatment and rehabilitation**

The law outlines a system of health care that emphasizes the integration of mental health into general health care at primary and secondary levels. It also states that health services must promote the provision of community based care, treatment and rehabilitation services. In addition psychiatric hospitals (for people with mental illness) and care and rehabilitation centers (for people with severe and profound intellectual disability) are set up by the legislation to admit and care for particular categories of users such as assisted and involuntary users, mentally ill offenders, mentally ill prisoners and voluntary users into specialized programmes. The vast majority of care should take place at primary care level, followed by secondary and lastly tertiary services.

**Rights and duties relating to mental health care users**

Various rights are outlined and explained. These include:
1) Respect, human dignity and privacy
2) Consent to care, treatment and rehabilitation services and admission to health establishments
3) Unfair discrimination
4) Exploitation and abuse
5) Determinations concerning mental health status
6) Disclosure of information

7) Limitations on intimate adult relationships
8) Right to representation
9) Discharge reports and
10) Knowledge of rights.

**Mental Health Review Boards**

Mental health Review Boards are set up by the law to make decisions with regard to the admission and treatment of assisted and involuntary users. They must also hear appeals against decisions to admit and treat users without their informed consent and on a periodic basis consider all users who are deemed to require longer term care.
also consider applications for transfers to maximum security facilities and receive complaints of abuse or exploitation. Review Boards consist of at least one community member, one legal practitioner and one mental health care practitioner.

**Voluntary, assisted and involuntary mental health care**
Voluntary care is encouraged. Criteria for when a person may be admitted as an assisted or involuntary user are outlined. Where a person refuses admission, in addition to being mentally ill to the extent that they lack capacity to make informed decisions the mental illness must be of such a nature that i)the user is likely to inflict serious harm to himself or herself or others ii)care, treatment and rehabilitation of the user is necessary for the protection of the financial interests or reputation of the user.

Processes for assisted and involuntary users are outlined. In both instances an application must be made and the user must be examined by two mental health care practitioners to determine whether they meet the criteria for admission. In the case of involuntary users they must initially also be admitted to a facility for a period of 72 hours where observation and a thorough assessment of the need for involuntary care is conducted. Involuntary care may be provided in either a mental health facility or in the community. A Review Board must then decide whether the assisted or involuntary admission is necessary. A judicial review must follow. Following admission all assisted and involuntary admissions must be reviewed on a periodic basis. Users may appeal against their admission and treatment. Any user who recovers to the point that they no longer meet the requirements for assisted or involuntary care may be discharged by the facility where they are admitted.

**State patients (mentally ill offenders)**
While mentally ill offenders are admitted through the Criminal Procedure Act, they are discharged via the Mental Health care Act. Users may also receive “conditional discharges”.

**Mentally ill prisoners**
If a prisoner becomes mentally ill to the extent that they need to be treated in a mental health facilities they can to transferred to such facility until they recover and can be returned to prison.

**Care and administration of property**
Procedures for the high court to appoint a person to administer the property of a person with mental illness or intellectual disability is outlined.
Suggested citation