Improving Mental Health in Ghana

Report on Curriculum Evaluation meeting

Community Mental health and Clinical Psychiatry Programmes

College of Health, Kintampo 21st – 24th February, 2012

[Compiled by]

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INTRODUCTION

The meeting was organized to review the Community Mental Health and Clinical Psychiatry Programmes at The College of Health, Kintampo.

Purpose of the meeting

The purpose of the meeting was;

To inform and to increase the awareness of key stakeholders about the on-going development of the Community Mental Health and Clinical Psychiatry programmes and the challenges that have been met so far.

For the participants to contribute, from their particular perspective, their views on ways to solve any problems that have arisen and to agree on any changes that need to be made that would improve the Community Mental Health and Clinical Psychiatry Programmes at The College of Health, Kintampo and how those changes might be achieved.

For the MAP and CMHO curricula to be evaluated by countrywide stakeholders and beneficiaries including a UK independent external expert with the eventual aim that new updated MAP and CMHO curriculum documents would be produced.

The bring together education, service and workforce stakeholders for the evaluation

To trial and start the introduction of improved education quality assurance procedures across The Kintampo College of Health using the meeting as an example of good practice

Themes for the meeting

The key themes that guided the meeting were:

- whether the training courses were meeting the need to scale up community mental health services;
- whether the job descriptions / intended practice, for the MAP and CMHO is what is needed;
- whether there were any changes needed to the curriculum;
- whether the education / service / workforce balance and model was correct;
- how the intake of the Clinical Psychiatry Programme could be improved;
- how awareness of the programmes and new practitioners could be increased and
- what needs to be done for the 'project' to be self-sustaining by 2018.

DAY ONE ACTIVITIES

The day began with an opening prayer by Rev. Father Peter Gyabaah Kumor. This was followed by registration of participants. Ms. Sally Gore was introduced by Ms. Ithiel Korkor Zotorvie as the moderator for the day. There was self-introduction of participants and organizers of the meeting.

Dr. E.T. Adjase (Project Lead for Ghana) welcomed all the participants and outlined the purpose of the meeting. This was followed by presentations on key issues. These were:

- Overview of the Kintampo Project
- Community Mental Health Curriculum Implementation Processes and Challenges
- Clinical Psychiatry Curriculum Implementation Processes and Challenges
- Curriculum Review Processes and Challenges at the University of Winchester
- Curriculum Review Processes and Challenges at the University of Education – Winneba (UoEW) Kumasi campus
- Factors to consider in reviewing a curriculum: the MOH/GHS Perspective
- Curriculum Review Processes and Challenges at the Community Health Department of KNUST

Overview of the Kintampo Project

Dr. Mark Roberts (Project Lead for UK) gave an overview of the Kintampo Project. He indicated that there are three psychiatric hospitals in Ghana that provides services for over 24 million people in the country. It was against this background that the project was established to train more community mental health professionals and educators to bridge the gap of inadequate mental health service providers. He further added that the changes the project has made include renewed enthusiasm and commitment, active networking in Ghana at national and regional levels.

Community Mental Health Curriculum Implementation Processes and Challenges

Mr. Emmanuel Okyere (Programme Head for the Diploma Community Mental Health) highlighted on the Community Mental Health Curriculum Implementation Processes and Challenges.

He cited some of the challenges as inadequate transport and accommodation at the College and practice placement/field sites. Inadequate number of resident tutors and inability to achieve the 70: 30 (practice / direct teaching) split.

He indicated that some adjustments have already been made in the curriculum. These include changing the “one week field visit for three consecutive occasions to two weeks continuously” and five weeks for practical and research work adjusted to six weeks.

Irrespective of the challenges, many successes / achievements have been made. These include the provision of the Kintampo ‘Psychosocial Centre’, classrooms and an office for visiting tutors.

Clinical Psychiatry Curriculum Implementation Processes and Challenges

Mr. Emmanuel Ofori (Programme Head for Clinical Psychiatry) presented on Clinical Psychiatry Curriculum Implementation Processes and Challenges. He gave an overview of the entry requirement and job description.

Mr Ofori reported that some of the challenges the programme is faced with have been low intake of Medical Assistants into the programme and inadequate transport at field sites. He indicated that the programme has been able to achieve the 70:30 split using Pantang Psychiatric hospital, Ankaful Psychiatric hospital, Accra Psychiatric hospital and Sunyani Regional Hospital Psychiatric unit as hub field sites.

Discussion

There was a question on, ‘how the adjustment in field placement duration for the Community Health Programme had been done and whether there had been difficulties’. The programme head said the decision to make the adjustment was based on feedback received from preceptors and students after the field practice and there had been no difficulty in making the adjustment

There was a question on ‘how long the (Kintampo) Project will last”. Dr. Adjase indicated that the college is equipping the trainees with the necessary knowledge and skills to continue after the UK partners have withdrawn. He said there will be a whole session on ‘ways of sustaining the Project’ after 2018.

Curriculum Review Processes and Challenges at the University of Winchester

Dr. Bridget Egan (University of Winchester, UK.) presented on curriculum review processes and challenges at University of Winchester. She indicated that a good curriculum produces graduates who are highly competent, aware of their further professional development targets and needs, good learners, flexible and versatile and able to be creative in their field.

The main challenge at the University is getting students to comment on the curriculum review process.

Curriculum Review Processes and Challenges at the University of Education – Winneba (UoEW) Kumasi campus

Dr. Kwadwo Mensah presented on curriculum review process and challenges at University of Education, Winneba - Kumasi Campus. He said, the main challenge the department is faced with is that on most occasions, needs assessment are not conducted before curriculum is reviewed because in reality their curricula are very rarely reviewed.

Factors to consider in reviewing a curriculum: the MOH/GHS Perspective

Mr. Said Al – Hussein (Deputy Director Human Resources, GHS, HQ) presented on behalf of the Ghana Health Service, supported by Mr Alex Gabby Hottordze (Deputy Director, HRHD, MoH) and Ministry of Health. They said that curriculum is a dynamic guide to developing human resources and a curriculum has a life of at most 5 years after which it has to be reviewed but for sake of health of the people, and with the rapid changes being seen in Ghana this should be more frequent than the five years; perhaps 3 years.

There were concerns regarding conditions of service but Dr. E.T. Adjase said that it would be addressed more appropriately on Thursday and Friday (23rd and 24th) February, 2012, when the District Directors, Regional Directors and other Senior Managers of Health would be available.

Curriculum Review Processes and Challenges at the Community Health Department of KNUST

Professor Ernestina Akosua Addy presented on Curriculum Review Processes and Challenges at the Community Health Department of KNUST. She highlighted that information is a necessary foundation for planning curriculum review. She indicated that curriculum evaluation has not been a feature of programme development at SMS, KNUST. She said that the participation of Head of Institution is crucial in the review process and there is the need to have a Curriculum Review committee responsible for curriculum review process.

Group work followed after the presentations and discussions. Four groups were formed to work on what is going on well and what needs more attention as far as the Clinical Psychiatry and the Community Mental Health programmes were concerned.

Group work presentations

What is going on well?

The groups came out with the following:

- Good educational methods
- Adjustments have been made to improve the performance of students
- Efficient lecturers
- Good experiential practical programme
- Students: tutor assessment occurs 'both directions'
- Students feedback was acted upon
- The 70:30 split being successfully implemented for the Clinical Psychiatry Programme
- High number of applications for the CMHO programme
- Psychosocial Centre is available for teaching and learning
- Transport and accommodation arrangements from College to the field have so far been successful despite the lack of availability
- From the Preceptors: students of CoHK are eager to learn
- Reflective practice, portfolio and PDP have all enhanced learning
- Effective collaboration between the CoHK, UK team and field placement sites
- Logbook and assessment forms have been very useful
- Graduates are using and transferring skills in practice

Issues that need attention

Based on the group presentation, the following were identified as issues that could be improved:

Entry into the programmes

- Support and release from Regional and District Directors of health services
- Low number of applicants for the Clinical Psychiatry programme
- Low publicity of the Clinical Psychiatry programme
- More awareness creation of the programmes

Organising the programmes

- The programmes are not overseen by clinicians (the Programme Heads are not clinicians)
- Review of course content needed
- Some topics are overemphasized
- 70:30 split not being achieved for CMHO programme
- Professional Exams (Community Mental Health) too loaded (too many papers)
- The Assessment process, particularly making better use of input from field sites.
- Too many assessments in both programmes
- Better communication needed with mental health care service providers
- Inadequate contact hours for external lecturers

Physical resources generally

- Not enough residential tutors
- Overcrowded classrooms
- Poor acoustics in the classrooms (e.g. need more use of PA system)
- Not enough teaching and learning materials
- Inadequate textbooks, projectors and other Teaching - Learning materials
- Preceptors teaching too many students at the same time
- ICT not adequate
- Psychosocial Centre needs more resources to function (more teaching space and a full time administrator / receptionist
- Lack of transport at the practical / field sites
- Internal (field) transport arrangements for the two programmes must be improved
- Accommodation pressures (availability and cost) during field placement

Course content / syllabus

- Skull x-ray reading should probably be part of the Clinical Psychiatry programme
- Psychology and Psychiatry should be separated
- Career progression opportunities not meeting practitioner demands and expectations following graduation
- Some input on Neurology needed in the Clinical Psychiatry programme

Service and workforce

- Job description (on paper) for both programmes not well enough understood and clarified with regard to that of Community Psychiatric Nurses

Afterwards, each group was tasked to select their four topmost issues they feel need more attention.

Four Top most issues that need attention

For all the four groups, the following were identified as the four top most issues that need attention

1. Low number of applicants for the Clinical Psychiatry programme
2. 70:30 split not being achieved for CMHO programme
3. Psychosocial Centre needs more resources to function (more teaching space and a full time administrator / receptionist (this is linked to item 2)
4. Inadequate number of residential tutors

The last activity for the day was for two groups each to work on how to:

- Achieve the 70 : 30 split for CMH programme, and
- Get more applicants for the Clinical Psychiatry programme.

The groups were asked to present the group work on the next day (22-02-2012).

Dr. E.T. Adjase said the closing remarks and indicated that, certificates would be awarded to all participants.

Closing prayer was said by Rev. Fr. Peter Gyabaah Kumor around 5: 30 pm.

DAY TWO ACTIVITIES

The opening prayer was said by Rev. Father Peter Gyabaah Kumor followed by registration of participants.

Ms. Sally Gore was the moderator for the day.

The previous day's report was read and the omissions and commissions were effected.

The moderator called on Dr. Adjase to go through the job descriptions for both MAPs and CMHOs.

In his presentation, he touched on the key headings of their job descriptions. He said that the qualified CMHO among other things is expected to:

- Support in providing holistic mental health care at the community level along with existing health care professionals including CPNs and other mental health care providers under the supervision of MAP.
- Provide psychological and social support for the families and carers of patients, education about mental disorders and will have links with groups such as the police, churches, traditional healers and schools.
- Identify psychiatric conditions and refer them to CPNs and MAPs.

He said the job descriptions informed the college of the syllabic content of the course.

For the MAP, he said they will be privileged to limiting their practice mainly to managing the following clinical conditions:

- Schizophrenia,
- Bipolar Affective Disorder (Manic depression)
- Depressive Disorder
- Hazardous alcohol use

- Epilepsy

and

- Refer cases as appropriate to the psychiatrist
- And other assigned duties under the supervision of a psychiatrist.

He highlighted on the administrative duties of the MAP and emphasized that they will work within the formal code of conduct of statutory and professional associations.

He then asked participants to go through the curriculum document and note any changes that need to be effected.

Discussions

There were concerns about the limitations of what the MAP will do. In response Dr. Adjase advised the MAP and CMHO will be in a privileged position and can refer cases appropriately. The MAP and CMHO will be able to practice in those areas of mental health with the best evidence for effective treatment thereby making the best possible use of their precious time. He further stated that the MAPs should not assume specialist proficiency especially when dealing with child psychiatric cases because along with sone other fields child psychiatry is a technical specialist area.

Group Presentation

Groups one and three presented on problems and issues resulting from 70:30 split and possible solutions whilst groups two and four presented on problems and issues resulting from low MAP intake and possible solutions.

70:30 split – problems and solutions

The two groups identified the following problems:

- When students are in College there aren't enough clinical placements in Kintampo – so when in college the 70:30 balance is not adequate
- It is difficult to organize practical sessions for large number of students when in College

- The timing of field placements too often coincides with that of other students on placements resulting in pressure on preceptors and overcrowding of facilities.
- Inadequate number of trained preceptors.
- Lack of understanding amongst tutors on how to provide teaching which involves practical experience
- Tutors not providing enough practical sessions
- Psychosocial Centre not functioning well enough yet

Possible solutions suggested by the groups were:

- Explore other facilities within the Kintampo area for practical placements
- Students should be in small groups for practical sessions both in Kintampo and other field sites
- Work out timetables in a more creative manner that allows students to be placed at different times.
- Train more preceptors to expand the hub and spoke model.
- Orientation of tutors about need for practical experience both in the classroom and on the field
- Get Psychosocial Centre functioning more by ensuring that there is:
    - Sufficient space for both teaching and clinical practice
    - Regular senior clinical staff (clinical psychologist, clinical psychotherapist)
    - Regular junior clinical staff
    - Permanent secretary/receptionist
    - Regular and reliable transport e.g. Motorbike
- Increase public education/public awareness (e.g. Fm radio/megaphone)
- Regular and reliable supply of medication
- Orientation of the tutors and the students in the need and rational for practicals and what they are
- Developing a system to enable sharing of good practice
- Strenthening preceptor development for the Kintampo precpetor

Low intake into the Clinical Psychiatry Programme

Causes suggested by the two groups were:

- Stigmatization attached to mental health practitioners.
- Worries about low remuneration (not on salary spine yet).

- Health authorities reluctant to release applicants.
- Inadequate publicity.
- Age barrier.
- Worries that there are inadequate Medical Assistants in the system (driven by policy makers not accessing information on the true picture of large numbers of MAs).
- Worries about lack of clarity on job descriptions for MAP / CMHO and CPNs
- Worries about lack of career pathway opportunities after graduation
- Title (MAP) not attractive to the future practitioners as it contains the word 'Assistant'

Possible solutions

- Clarify salaries and make them attractive
- Good conditions of service.
- Sponsorship of the Clinical Psychiatry programme by MoH and GHS.
- Increase the awareness creation of the programme by using existing regional/district director's conferences, the media, etc.
- Increase MOH and GHS effectiveness in solving the issues faced by the programme.
- Consider organising the programme on a Sandwich basis
- 'Career progression' should be established
- Bring together all relevant stakeholders to discuss the selection process and entry criteria.
- The job description of the MAP should be clearly spelt out by GHS
- Strengthening the collaboration between the college and MoH/GHS
- Graduates could be called by a title other than MAP eg. Clinical Psychiatric Officer (GHS would need to decide)

The moderator reshuffled the groups and asked two groups each to work on one of these:

- General conditions of service for mental health professionals
- Strengthening hub and spoke model.

Before the group work was done, Dr. Adjase briefed the participants about the importance of field sites for training. He said that field sites are where the trainees could put theory into practice and gain more practical experience. He further stated that this will work best when there are more hubs and spoke

sites, hence the invitation of the regional and district directors at the meeting was opportune to allow further discussion ways of implementing the hub and spoke model at the regional and district levels.

Representative of the Community Mental Health programme at the meeting mentioned some of the challenges at the field as lack of recognition and conflict with other analogous grades of mental health staff.

There was a comment on the low publicity of the programme by one of the participants. In response Mr. Ofori (Clinical Psychiatric Programme head) said he has done his best about the publicity of the programme and he believes it is due to lack of interest on the part of the practicing Medical Assistants. To buttress Mr. Ofori's point, Dr. J .B Asare said he had a similar experience and stated what motivate the people is their interest. He said the Mental Health Bill was being discussed in parliament and the bill may be passed into Law by the weekend and this he believes will motivate people to develop interest in mental health. He further urged the mental health workers and trainees to exercise patience.

Group Work

General Conditions of Service for Mental Health Professionals

The groups came out with the following as general conditions of service:

Challenges in mental health:

- Social stigma and perception of Mental Health. Within some districts, mental health is not accepted.
- The risk involved in working with mental health patients. The patient can be abusive, resulting in the work being more distressing and stressful.
- Poor working environment.

Conditions that would make the job functional/efficient:

- Unique and attractive salaries.
- Mental Health workers deserve a higher salary than other health workers, as they tend to work in neglected areas, the risky nature of the work coupled with the increased workload as there are fewer Mental Health workers.
- Supply of uniforms.

- Provision of free accommodation (or a rent allowance).
- Provision of means of transport and other logistics. Even motorbikes would do.
- A good working environment or offices for the workers.
- Development of Communication directory. A country wide directory containing the contact details of all Mental Health workers.
- Good communication.
- Creating a package with a mobile network to give free calls to other Health workers within the network. For example, Vodafone is working with doctors to provide a similar package.

<u>Conditions that could create an attractive package.</u>

- Fast tracking promotions for mental Health workers. Possibly reducing the course length after a number of years within a service.
- Organizing more CPD Programmes. Refresher courses to maintain interest in mental health and help widen the knowledge base of the workforce, e.g. Regional Conferences or workshops.
- Provision of tools, logistics and equipment to enhance work.
- Development of the Communication Directory.
- Provision of accommodation for workers.
- Possible early retirement on their salary or a similar amount.
- More courses or Master degrees in Psychiatry to give a clear-cut career and future development.

Strengthening hub and spoke model.

The groups came out that if the following are implemented it could strengthen the hub and spoke model. The groups categorized the presentation into challenges, human resource, material needs, financial and benefits.

Challenges

- It is important to ensure this is not seen as an isolated (vertical) programme because it is not
- Mental health is a stigmatized field of practice
- Mental health not a strong funds generator

Human resource

- Appoint and recognise educators (to community level)
- Release educators to train and educate (and prepare for students to arrive)
- Support meetings to prepare for students
- Appoint lead administrator and clinician for mental health programmes at least in each Region / District in which there is a preceptor
- Advocate for mental health service providers
- Social responsibility – see mental health as a special case

Material needs

- Book for preceptors and students
- Place for library and books at hub and spoke sites
- Clinic space for teaching
- Communication support
- Office space
- Transport
- Student Accommodation

Financial

- The groups suggested that perhaps funds could be solicited from NGOs and Religious bodies to support the hub and spoke sites. Further, fundraising and lobbying activities could be done to raise funds to support the programme.

Benefits

Benefits associated with the hub and spoke model were identified by the groups as:

- Better health service
- Service diversity
- Increased job satisfaction
- Social Responsibility

The activities of the day came to an end at 5:00pm with a closing prayer by Rev. Father Peter Gyabaah Kumor.

DAY THREE ACTIVITIES

The day started with an open prayer by Rev. Fr. Peter Gyabaah Kumor.

Ms. Sally Gore was the moderator.

The previous day's report was read and the omissions and commissions were effected.

There was self introduction by the participants because the Regional and District Directors of Health Services joined the meeting.

Dr. Mark Roberts gave an overview of the Kintampo Project. He said that majority of the UK Team work with the Southern Health NHS Foundation Trust. He mentioned the executives, the staff strength and the services that the Southern Health NHS Foundation Trust provides.

He stated that the project is a partnership between UK NHS and MoH/ GHS – Ghana. The objective of the project is to scale up mental health workforce in Ghana between 2006 to 2018 with emphasis on community mental health. In response to the objective of the project, two new training programmes (Clinical Psychiatry Programme & Community Mental Health) were introduced in 2010 at College of Health, Kintampo. He indicated the project depends on grants for its operation and became charity organization in the U.K. in 2011. The target is to have in each district in Ghana one (1) MAP and two – three (2-3) CMHO.

After Dr. Mark Robert's presentation, a participant wanted to know the initial target output of the Clinical Psychiatry Programme. In response, Dr. Adjase said 40 was the initial target with the breakdown as follows:

- three applicants each from the ten regions,
- three applicants each from the three psychiatric hospitals and
- one applicant from any of the quasi institutions.

In reaction, Dr. Koku Awoonor Williams (Upper East Regional Director of Health Services) said the regions were not aware of releasing three Medical Assistant each to enroll into the Clinical Psychiatry Programme.

Dr Atsu Seake-Kwawu (Municipal Director of Health Services – Ho) suggested that attention should be focused on the Direct Medical Assistant since they are very young and energetic to work for a longer time.

Dr. Adjase said the graduates of these two programmes - MAP and CMHO would be regulated by Ghana Medical & Dental Council AND Allied Health Professionals respectively.

The moderator introduced the topics for the day and those who were to lead the discussion as:

- Challenges of MAP and CMHO placements – Dr. Awoonor Williams
- General conditions of service – Dr. J.B. Asare
- Low MAP intake - Dr. Adjase
- Establishment and strengthening the Hub and Spoke model – Dr. Mark Roberts

Challenges of MAP and CMHO placement.

Dr. Awoonor –Williams who led discussions on the challenges of MAP and CMHO placement said that the CMHO should not be restricted to only psychiatry but they should be in a position to combine previous and current knowledge to provide holistic service. He indicated that the primary responsibility of the CMHO is mental health care but they can and should perform other roles when the need arises.

He agreed placement of CMHO should be at the sub district level (CHPS zone and health centers).

He felt most of the Community Mental Health applicants are not driven by interest in mental health service but by way of career and professional progression. He further stated that the college must do something to generate interest in the trainees. He indicated that there is the need for the MoH to create career pathway for both programmes

In response to the issues raised by Dr. Awoonor-Williams, Rev. Father Kumor was of the opinion that the greatest motivation for the CMH trainees is the syllabic content of the curriculum.

Dr. J.B. Asare stated that the programme was for a purpose i.e. 'to bridge the gap in mental health workforce', hence there is the need to clearly spell out what they are expected to do.

Dr. Nuertey (Regional Director of Health Services, Volta Region) indicated that the physical structures should be in place at all levels for the graduates to operate.

General conditions of service for mental health practitioners

Dr. J.B. Asare who led the discussions stated that the mental health bill has a lot of attractive packages in that the mental health service would be a semi-autonomous body. When the bill is passed it would address some of the problems relating to conditions of service. For example there would be:

- Incentives for rural mental health practitioner
- Opportunities to attend courses and upgrading.
- Mental health fund.

The participants agreed that the following would help to overcome challenges;

- Good working environment (good infrastructure).
- Provision of logistics and resources.
- Given of citations.
- Self motivation by practitioner themselves
- Career progression.
- Sponsorship and proper placements.

Low MAP intake

Dr. Adjase led discussions on the topic. He stated with evidence that there were enough practicing Medical Assistants in the system who could apply for the Clinical Psychiatric programme.

Some of the participants raised the following issues as the probable causes of the low intake into the Clinical Psychiatry programme:

- Poor advertisement.
- Lack of interest.
- Maldistribution of MA's that makes it impossible for some regions to release the few onto the programme.
- Issues of career progression, placement and salary scales are not spelt out

The following were suggested by the participants:

- Clinical Psychiatry programme could be three years for the Registered Mental Nurses where the applicants will use one year for the Medical Assistants Programme and two years for the Clinical Psychiatry Programme (CPP).
- Is there a possibility of direct entry into the CPP using Senior High School graduates?
- Sensitization of district assemblies to support CPP intake.
- More awareness creation is needed especially to the districts and regional health directorates.
- Creation of mental health units in the facilities

Action to be taken

- MoH/GHS representative at the meeting stated that the issues raised concerning career progression, placement, salary scales and job description would be discussed with the Chief Director and a MoH/ GHS stakeholders meeting would be organized involving some more Regional Directors of health services, District Directors of health services, Director of the College, Faculty Members of the college, former chief psychiatrist and current chief psychiatrist.
- Dr. Adjase stated that he will communicate more with the Regional and the District directors concerning the programmes.
- Dr. Awoonor Williams promised that he will use the next regional directors' meeting as an entry point to advance the programmes.

For details of action to be taken, go to appendix one

According to the representative from the MoH/GHS, a policy to address issues of mal-distribution of health workforce is being developed.

Establishment and strengthening the Hub and Spoke model

Dr. Mark Roberts led discussions on the hub and spoke model. He said the 'hub' is the main field site whiles the 'spoke' is the peripheral field site. He indicated that the essence of the model is to identify ways to make learning effective for students on placements.

All the directors present agreed to support the hub and spoke model and students who would be posted to their outfit. However, there was a suggestion that it might help if the model could be put in a form of proposal and send to the regions, districts and other stakeholders.

Rev. father Peter Gyabaah Kumor said the closing prayer.

DAY FOUR ACTIVITIES

The opening prayer was said by Mr. Elvis Akuamoah. Ms. Sally Gore was the moderator.

Dr. E.T. Adjase welcomed all participants.

The previous day's report was read and the necessary omissions and commissions were effected. Afterwards, the chief Psychiatrist, Dr. Akwasi Osei briefed participants on the state of mental health bill.

He stated that we are in a transition stage and by five years' time mental health would be very attractive field. He further indicated that the bill is supposed to go through three stages before it is passed and the mental health bill has about 91 clauses which is more than any other bill. The parliament and its committee have looked at 35 of the clauses so far.

He further mentioned that mental health in Ghana hinges on 5 pillars which make it unattractive. These are:

- Centralized care
- Institutionalized
- Highly stigmatized
- Under resourced and
- Over medicalized (in the sense that structures for other staff such as clinical psychologist, occupational therapist, social workers are not there).

The bill therefore seeks to address these inadequacies.

He assured participants that the passage of the bill would be welcomed with a big bang ceremony.

A participant was not happy with the fact that the GHS do not have a salary level for professionals such as psychotherapist and clinical psychologist. In response, Dr. Akwasi Osei said that the bill takes cognisance of psychotherapist, clinical psychologist, faith based healers, and other mental health care providers.

He stated that there will be a relationship between mental health authority (service) and other health care bodies. He further said that every regional hospital will have mental health unit. However, the activities of those units will not run on parallel bases but would be integrated into the GHS structures.

Dr. Adjase said the integration should be well planned and the structures need to be put in place in order to reduce frustrations.

Dr. Atsu wanted to know since we are advocating for deinstitutionalization, what will be the role of the psychiatric institutions?

In response, Dr, Akwasi Osei stated that, GHS will work with Mental Health Authority to scale up psychosocial interventions and emphasize on community based care, hence the institutions will serve as referral for specialist care.

Dr. Koku Awoonor reiterated that in his view the CMHO's are not driven by interest but by way of career progression. Therefore there is the need for a clear cut career progression designed for them otherwise by five years' time those trained will leave the scene and patronise other courses.

In response, Mr. Alexander Gabbi Hottordze (MoH representative) said he would discuss it with the head of department at the University of Cape Coast for the BSc. Community Psychiatry Programme.

There were representative from various media houses namely Radio Ghana, Adars FM, Daily Guide and TV Africa. Mdme. Amina Bukari (National Coordinator of CPNs) encouraged the media practitioners to use their office to demystify stigmatization associated with mental health.

Participants were presented with certificate at the end of the meeting.

Closing prayer was said by Rev. Father Peter Gyabaah Kumor.

APPENDIX ONE

MAP / CMHO PROGRAMME CURRICULUM EVALUATION MEETING - ACTION PLAN

COLLEGE OF HEALTH, KINTAMPO

FEBRUARY 2012

Item	Objective	Activity	Person Responsible	Time
1	To develop and operationalise the psychosocial centre in Kintampo (Education)	1.1 Maintain effective communication and good working relationship with all partners involved	Rev.Fr.Peter Gyabaah Kumor (lead) Mr. Peter Adams	To be determined
		1.2 Produce and implement an action plan to negotiate for local support from the community	Rev.Fr.Peter Gyabaah Kumor (lead) Mr. Peter Adams	To be determined
		1.3 Produce and implement an action plan to ensure effective community links with service delivery	Rev.Fr.Peter Gyabaah Kumor (lead) Mr. Peter Adams	To be determined
		1.4 Equip the facility with necessary teaching /learning materials and resources.	Dr. Gwyn Grout	To be determined

		1.5 Build an extension for teaching rooms and better waiting facilities for patients and dependents	Dr Adjase	September 2012
		1.6 Appoint a Regional Lead Preceptor for Brong Ahafo Region based in Kintampo rather than the regional capital Sunyani. In the first instance Reverend Father Peter to take this on and Isaac Adjei, first year CMHO working in Kintampo for the Psychosocial Clinic to start Acting Deputy Lead Preceptor and be tutored and coached by Father Peter to become the Regional Lead	Dr Adjase	March 2012 onwards
		1.7 Develop and strengthen five (5) "hub "sites in Kintampo North Municipal and South District – action plan to be produced	Mr.Peter Adams	To be determined
2	Strengthen the hub and spoke clinical placement sites (education)	2.1 Identify and train people in the communities to promote local ownership of the programme at the "hub" sites.	Rev.Fr.Peter Gyabaah Kumor (lead) Mr Peter Adams	To be determined
		2.2 Discuss with colleagues at Regional Directors' meeting to put structures in place to embrace the "hub and spoke" concept.	Dr Joseph Nuertey Dr Koku Awoonor Williams	Feb- March, 2012
		2.3 Write-up the Hub and Spoke model requirements in a	Dr Joseph	By 30th

		format that makes sense for Regional Directors. To be done in consultation with the Programme Heads.	Nuertey (lead) Mr Emmanuel Ofori Mr Emmanuel Okyere	February 2012
3	Increase the Clinical Psychiatry (MAP) programme intake at CoHK to achieve the target of at least one (1) MAP in all 212 districts of Ghana by 2018 (workforce / service).	3.1 mprove awareness about the Clinical Psychiatry programme.	College staff	To be determined
		3.2 Advocate the Clinical Psychiatry programme to policy makers and other health professional groups at regional and district directors meetings. And specifically Dr Awoonor Williams to raise awareness by emailing the Curriculum Evaluation briefing pack to Regional Directors and will mention the programmes at the Regional Directors Meeting taking place week beginning 27.02.12 in Kumasi – it will be minuted to show that it was discussed.	Dr Atsu Seake Kwawu Dr Koku Awoonor Williams Dr Joseph Nuertey	March, 2012 & May –June, 2012
		3.3 Arrange for Dr Adjase to be invited to make a presentation at the District Directors' Conference in Wa in May/June this year.	Dr Koku Awoonor-Williams	March 2012
		3.4 Undertake awareness raising by (1) mentioning the programmes in the District Director's Newsletter and (2) to send an invitation to Dr Adjase to attend the	Dr Atsu Seake Kwawu	March 2012 onwards

		District Directors' Annual General Meeting to talk about the programmes. Mentioning it in the Newsletter will be preparatory to talking about at their Annual General Meeting.		
		3.5 Boost the confidence of prospective applicants by ensuring equitable distribution of the qualified Medical Assistants to the regions.	Mr Said Al-Hussein Mr Alexander Gabbi Hottordze	By the end of 2012
		3.6 Raise awareness by inviting the Director of the college to give a presentation on the two new mental health programmes during mental health annual review meeting..	Dr. Akwasi Osei	March 2012
		3.7 Raise awareness of the programmes by making clear mention of them at the National 'Senior Managers Meeting' and the Ghana Health Summit.	Dr Akwasi Osei	March 2012
		3.8 Lobby Ministers to inform District Assemblies about the MAP / CMHO programmes	Dr Akwasi Osei	March 2012 onwards
		3.9 Brief the Minister and Chief Director on the issues discussed at the meeting and give feedback to the Director of the college	Mr Alexander Gabbi Hottordze	1st March, 2012
		3.10 Encourage the Minister of Health to create awareness about the clinical psychiatry programme at Senior Managers meeting and Health Summit	Mr Alexander Gabbi Hottordze.	April, 2012

		3.11 Organise a stakeholder meeting in Accra MoH and GHS Chief Directors, Directors, Regional Directors, District Directors, College staff and other relevant stakeholders, to raise awareness and finalise agreement on the way ahead (job descriptions, salary, management lines, titles, career progression etc).	Mr Alexander Gabbi Hottordze.	By the end of May, 2012
		3.12 Contribute to awareness raising by informing the Medical Directors and Medical Superintendents and Chairpersons of meetings across his region about the MAP and CMHO programmes and asking them to support Practitioners to enrol on them.	Dr Atsu Seake Kwawu	By the end of Feb, 2012
4	Improve MAP and CMHO practitioner service conditions and provide career opportunities for the two new cadres of mental health workforce (service and workforce)	4.1 Organize meeting to brief the Director of Human Resource, GHS.	Mr Said Al-Hussein.	As early as possible
		4.2 Produce well-defined structures for placement and salary levels before the practising CMHOs finish their National service	Mr Said Al-Hussein.	By the end of August, 2012
		4.3 Ghana Health Service (the employer) to produce job descriptions for the 'MAP' and 'CMHO' (the curriculum documents at Appendix B contain descriptions of what the Practitioners will do, but these are not in the form of job description). Mr Said Al-Hussein produced draft job descriptions by the end of the meeting which were circulated for comments. As comments come in, updated soft copies will be produced and re-distributed for further comment. Mr Said Al-Hussein	Mr Said Al-Hussein.	By the end of August, 2012

		emphasises the need to distinguish the differences in role between MAPs, CMHOs and CPNs.		
		4.4 Discuss with the Head of Department at the University of Cape Coast; the accepted procedure to gain admission to the BSc. Community Psychiatry Programme	Mr Alexander Gabbi Hottordze.	As soon as possible
5	To review the syllabic content of the two curricula	5.1 Set up committee to review curriculum	Dr E.T. Adjase	24th February, 2012
		5.2 Edit and circulate the two curricula for Clinical Psychiatry and Community Mental Health programmes to all relevant stakeholders	Mr Emmanuel Okyere	End of March, 2012.
		5.3 Explore and develop the content of the two curricula into competency –based	Mr Emmanuel Okyere (lead) Mr Emmanuel Ofori Mr Said Al-Hussein,	End of April,2012
6	(Education) Review and update the Curriculum documents	6.1 Produce and issue first drafts of the new documents	Mr Emmanuel Okyere (lead) Mr Emmanuel Ofori	End of March 2012
7	(Education) Review the exam overload and	7.1 Undertake during curriculum document review	CoHK team (led by Mr Nii	

	assessment process	process.	Ashitey)	
8	(Education) There was a call to increase the number of resident Tutors for the programmes	8.1 Everyone agreed. Ithiel Korkor Zotorvie and Reverend Father Peter Gyabaah Komor are both joining as full-time faculty.	Nil	ACHIEVED
9	(Education) For the Curriculum document review to take in a process of considering whether Preceptors should have any input into the Licensure exam	9.1 Will be considered as part of the document updating	Mr Emmanuel Okyere (lead) Mr Emmanuel Ofori	End of March 2012
10	(Workforce) Ensure CMHO do not leave mental health (this arose because Regional Directors said they believe a lot of students who have enrolled on the CMHO course are not actually interested in mental health, but simply want to get a diploma qualification - The Regional Directors were predicting the CMHO would leave mental health –we didn't necessarily agree with them and there were some flaws in the argument, but it was important to hear their worries).	10.1 One of the CMHOs agreed to lead on working with Tutors to encourage her CMHO colleagues to stay in mental health once qualified. Start week beginning 27th February 2012 with a briefing to her class	CMHO 2nd intake class representative	27.02.12
11	Raise awareness and gather outcome information for CMHO practice	11.1 Brief CMHO Regional Services colleagues about the Curriculum Evaluation meeting.	Ms Gifty M Afetogbor	March 2012
		11.2 Lead on forming regional mental health groups who will meet every two to three months to show the progress	Ms Gifty M	March 2012

		of their work. Gifty will send updates every three months to Dr Roberts and Dr Adjase	Afetogbor	
12	Keep MAP and CMHO linked in with Mental Health Act developments.	12.1 Lead a small group who will develop their remit over the next two weeks then report back to Dr Adjase, Mark Roberts and Dr Akwasi Osei. 12.2 The group will make sure that Mental Health Act implementation planning keeps the MAP and CMHO development involved.	Mr Elvis Akuamoah	March 2012
13	(Education) Increase the clinical support for curriculum development	13.1For a Curriculum Content Technical Review Team to oversee the syllabic and clinical content of the courses. In the first instance the Team will consist of Dr Adjase, Emmanual Ofori, Emmanual Okyere, Dr J B Asare, Dr Akwasi Osei, Dr Mark Roberts and Dr Tetchie Jones, elvis Akuamoah and Ithiel Zotorvie but as we all think about the findings we may amend this.	Dr Mark Roberts	End of Feb 2012
14	Make the difference in the educational needs of CMHO and MAP clearer, to avoid them CMHO being taught at a level which is too deep for them (Education)	14.1 The two Programme Heads recommended that they undertake a piece of work to produce a guide to help tutors gauge how far to go. This was discussed very near the end of the meeting with little time left and the Programme Heads reported they will produce a competency based curriculum.	Mr Emmanuel Ofori (lead) Mr Emmanuel Okyere Mr Said Al-Hussein	By 31st May 2012
15	Achieve the 2018 targets for MAP and CMHO workforce numbers in Ghana (workforce)	15.1 Produce clear projected MAP and CMHO student intake requirements (the number per year) and inform	Mr Said Al-Hussein	By week commencing 27th February

		the CoHK of these.		2012
16	The MAP and CMHO students to have a good understanding of their programme and the requirements	16.1 Programme Heads to lead on helping the current students to produce a students handbook	Mr Emmanuel Ofori (lead) Mr Emmanuel Okyere	August 2012

APPENDIX 2

LIST OF ATTENDEES

Community Mental health and Clinical Psychiatry Programmes at College of Health, Kintampo 21st – 24th February, 2012.			
S/N	NAME	DESIGNATION	REGION
1	ITHIEL KORKOR ZOTORVIE	LEAD PRECEP. ANKAFUL PSY. HOSP.	CENTRAL
2	AKUAMOAH ELVIS	LEAD PRECEP. PANTANG HSOPITAL	ACCRA
3	GIFTY M. AFETOGBOR	PRECEPTOR, HO	VOLTA REGION
4	EMMANUEL NARTEY	CMHO CLASS REP	BRONG AHAFO
5	JESSICA AMOAH	CMHO/ EFFIA NKWANTA HOSPITAL	WESTERM
6	JOANA ACKON-ANNAN	CMHO/ CAPE COAST	CENTRAL
7	NAABDOYA FELICIA	CMHO/ PRECEPTOR	UPPER EAST

8	DORGBEFU FAFALI	CMHO REP (DEPUTY)	BRONG AHAFO
9	ADJEI ISAAC	CMHO PRECEPTOR	BRONG AHAFO
10	KWAKYE GIDEON	CMHO PRECEPTOR	EASTERN REGION
11	ALFRED QUARSHIE	MAP STUDENTS	G. ACCRA
12	AIDOO KINGSLEY WILLS	MAP STUDENNTS	CoHK
13	KPEN BRUCE	TUTOR	BRONG AHAFO
14	PATRICIA ABINAH YEBOAH	TUTOR	CoHK
15	TWUM PETER	HEALTH TUTOR	CoHK
16	PETER I. ADAMS	TUTOR - CMHO/MAP	CoHK
17	PETER GYABAAH KOMOR	TUTOR	CoHK
18	DR. KWADWO MENSAH	PART TIME LECTURER	CoHK
19	ABRAHAM MANU	TUTOR	CoHK
20	PROF. MRS. E. A. ADDY	LECTURER	SMS, KNUST
21	EMMANUEL OKYERE	PROGRAMME HEAD CMHO	CoHK
22	N. A. ASHITEY	DEP. DIRECTOR ACADEMICS	CoHK
23	DR. BRIDGET EGAN	UNIVERSITY OF WINCHESTER	UK
24	DR. MARK ROBERTS	KINTAMPO PROJECT UK LEAD	SHIFT
25	MISS SALLY GORE	KINTAMPO PROJECT	INDEPENDENT SUPPORT GROWTH
26	PROF. ROGER WOODS	EXTERNAL - UNIVERSITY OF WINCHESTER	UK
27	VICTORIA WHITE	KINTAMPO PROJECT	UK
28	DR. GWYN GROUT	KINTAMPO PROJECT UK	UK
29	ALEX GABBY HOTTODZE	HRHD	MOH,HD,ACCRA
30	SAID AL-HUSSEIN	DEP. DIRECTOR HRDD	GHS, HQ, ACCRA

31	ISAAC AZINDOW	TUTOR COLLEGE OF HEALTH	CoHK
32	RICHARD ALI LAAR	TUTOR - COLLEGE OF HEALTH	CoHK
33	PATIENCE TSRAH	TUTOR – COHK	CoHK
34	FRANCIS APPIAH	TUTOR – COHK	CoHK
35	GABRIEL KORANG	TUTOR – COHK	CoHK
36	EMMANUEL OFORI	TUTOR – COHK	CoHK
37	AKAGWIRE A. D.	DDNS (PSY)	UPPER EAST BOLGA
38	DR. J. B. ASARE	RTD CHIEF PYCHIATRY	ACCRA
39	JOANA GROUT	UNIVERSITY OF WINCHESTER	UK
40	REBECCA GORE	UNIVERSITY OF WINCHESTER	UK
41	ROGER WOODS	UNIVERSITY OF WINCHESTER	UK
42	BRIDGET EGAN	KINTAMPO PROJECT	UK
43	SALLY GORE	KINTAMPO PROJECT	UK
44	MARK ROBERTS	KINTAMPO PROJECT	UK
45	WIAFE DANIEL	TUTOR COLLEGE OF HEALTH	COHK
46	BIGHT AKPALU	TUTOR CMHO	CoHK
47	DR. JOSEPH NUERTEY	RDHS	VOLTA REGION
48	DR. ATSU SEAKE-KWAKU	MDHS HO	HO
49	MRS. BEATRICE KUNFAH	MDHSWA UWR	UPPER WEST
50	DR. KOKU AWOONOR WILLIAMS	RDHS UER	UPPER EAST
51	DR AKWASI OSEI	CHIEF PSYCHIATRIST	ACCRA
52	MADAM AMINA BUKARI	NATIONAL COORDINATOR FOR CPN	ACCRA