REPUBLIC OF SIERRA LEONE

MINISTRY OF HEALTH AND SANITATION

MENTAL HEALTH POLICY

2010 - 2015

Contents

FOREWORD

This Policy document marks a new beginning for mental health care in Sierra Leone. It is a statement of the commitment by the government of Sierra Leone to set clear directions for the development of mental health services and the promotion of mental health in the country. Based on an all-inclusive consultative process and current situation analysis, this policy will facilitate the integration of mental health services into the public health agenda and encourage an inter-sectoral approach to mental health, as well as reduce the burden of mental disorders in the population.

The policy clearly sets out the vision, values and principles, objectives and areas for action of mental health in Sierra Leone. The mental health policy is linked to the strategic plan, which identifies strategies, activities, time frames, responsible persons and indicators for the implementation of the policy. This policy will guide the revision of mental health legislation which is also a priority for the Ministry of Health and Sanitation.

The mental health policy was developed by a Core working group headed by the Directorate of Non-Communicable Diseases, which includes mental health, with contributions from a wide range of stakeholders in Sierra Leone. Technical assistance was provided by the WHO (Headquarters, African Regional Office and Country Office).

With the authority vested in me, I announce the adoption of the first mental health policy of Sierra Leone.

Hon. Minister of Health and Sanitation

ACKNOWLEDGEMENT

The implementation of this mental health policy is very essential for achieving health for all as there is no health without mental health. Currently, it is the renewed focus of the Ministry of Health and Sanitation to integrate mental health into primary health care as this is the only way we can bring mental health services close to where people live. Therefore, this policy which emphasizes such integration could not have come at a more appropriate time.

It is against this background that the Ministry of Health and Sanitation wishes to acknowledge the invaluable contribution of all actors who were involved in the formulation of this policy document.

The Ministry of Health and Sanitation is particularly grateful to the WHO for the technical support provided from all three levels (Headquarters in Geneva, Regional Office –AFRO in Brazzaville, and the WHO country office). The invaluable contribution and the leadership role of the Directorate of Non-Communicable Diseases in the formulation of this policy are also highly appreciated.

We are also very grateful to all the stakeholders, including City of Rest, Christian Health Association, College of Medicine and Allied Health Sciences, Centre for the Victims of Torture (CVT), and the Fatima institute for their invaluable contribution during the whole process.

Finally, we wish to acknowledge the role and contributions of Dr. Soccoh Kabbia, throughout the policy formulation process.

Dr Kisito S. Daoh

Chief Medical Officer

ACRONYMS

CHO	Community Health Officer
DMO	District Medical Officer
DHMT	District Health Management Team
DPNR	Directorate of Training, Non-Communicable Diseases and Research
HMIS	Health Management Information System
H&L	Hospital and Laboratories
HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome
MoHS	Ministry of Health and Sanitation
NGO	Non Governmental Organization
PHC	Primary Health Care
PHU	Peripheral Health Unit
PNR	Postgraduate Training, Non-Communicable Diseases and Research
PRSP	Poverty Reduction Strategy Programme
RCH	Reproductive and Child Health
TB	Tuberculosis
UN	United Nations
UNODC	United Nations Office on Drug Control
WHO	World Health Organization

INTRODUCTION

Mental health is an essential and integral component of health as defined by the World Health Organization (WHO). Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.

As is the case in most other countries in the sub-region, mental health has been a neglected area in Sierra Leone. According to WHO, 'mental health is a state of complete mental well being and not merely the absence of mental disorders or illness'. Mental health services in Sierra Leone have generally been hospital based and are not provided at primary and secondary levels of care. As a result, the treatment of patients far from their homes usually disrupts their normal daily life, employment and family life or prevents them from seeking treatment. Removing individuals from their normal family and community supports, which may be essential to their recovery, delays the recovery process, and In most instances, imposes more of a burden on families and health care providers.

Globally, as well as in Sierra Leone, there is increasing awareness of the need to shift the emphasis towards a community based mental health programme. Mental health services should be integrated into the overall primary health care (PHC) system and community-based psychosocial care services in the country. This is a major strategy to address access to mental health care for all. In addition, integrating mental health into primary care is the most viable way of closing the huge treatment gap and ensuring that people get the care they need. To be fully effective and efficient, mental health care must be coordinated with a network of services at different levels of care and complemented by a broader health system development. The potential reduction in the stigma associated with receiving mental health services in primary care where all the health care providers and the community members know each other can also mean that people with mental disorders and their families will be less likely to experience discrimination within their communities. Thus, the integration of mental health services into primary care will reduce the burden on individuals, families and society, thereby ensuring a smoother social integration, and better chances of recovery.

This is the renewed focus of the Ministry of Health and Sanitation (MoHS) particularly as Sierra Leone, in the post-conflict context, faces mental health issues arising directly or indirectly from high unemployment, domestic violence, trauma, depression associated with chronic diseases such as HIV/AIDS and tuberculosis, excessive consumption of alcohol, and other substance use, all major public health problems in the country. The country presently has only one psychiatric hospital which is grossly under staffed and uses outdated care protocols. The human resource needs are enormous as evidenced by the presence of only one psychiatrist, who is retired from active government service, and two trained psychiatric nurses who are trying to manage the 400 bed hospital.

In order to address the mental health problems in the country the following priority areas need to be considered:

- Reorganization of the mental health services
- Integration of mental health into other programmes such as reproductive and child health (RCH), school and adolescence health, HIV/AIDS and TB
- Human resource development for mental health
- Financing of mental health care services

SITUATION ANALYSIS

The capacity of the MOHS to deal with mental health is very limited due to the lack of trained personnel and other resources needed to run an effective mental health service. Prior to the decade long civil war there was only one psychiatrist in the country. Although there was no documented evidence of the mental health situation in the country, there was anecdotal evidence that mental disorders were on the increase; thereby creating a burden on the resource limited health delivery service of the country. During the war, there was a complete collapse of the health delivery system in most part of the country, including the kissy Mental Hospital. During this period, a huge burden of mental disorders was represented by double-diagnosis (co-morbidity between mental disorders and substance abuse).

In the immediate post conflict period, a national mental health survey conducted by WHO revealed prevalence rates of 2% (50,000) for psychosis; 4% (100,000) for severe depression; 4 %(100,000) for severe substance abuse; 1% (25,000) for mentally retarded and 1% (25,000) for epilepsy. Mental disorders in Sierra Leone cause a substantial burden due to the following factors.

- A very high percentage of people with mental disorders are not treated. Less than 1% are treated;

- The rate of relapse amongst treated individuals is very high;

- The mental health service is limited in scope and trained personnel;

- The mental health system serving psychiatric patients is weak;

- There is no community mental health care, and only one institution (Sierra Leone Mental Health Hospital) which is 183 years old.

The hospital has one consultant who is retired, one medical officer and two qualified psychiatric nurses. The hospital can accommodate about 400 patients on average, most of them presenting co-morbid substance abuse and severe mental disorders. The hospital does not have the capacity to run and operate community follow up services, specialized therapy, drugs and alcohol services which are very important components of a nation's mental health system. In addition, psychotropic drugs are not available at the hospital. The last supply was in 2005.

Traditional healers and faith based organizations also contribute to the mental health delivery in Sierra Leone. Among them are the City of Rest (Freetown), which deals particularly with co-morbid cases, and, more recently, the Fatima Institute (Makeni), which provides mental health support and in-service training for nurses.

In summary, the treatment gap, consisting of the difference between the number of people in need of mental health care and the number of people actually receiving it, is currently huge in Sierra Leone.

VISION

To make available to all the people in Sierra Leone, in collaboration with a range of partners, affordable, accessible, sustainable and integrated high quality mental health services.

GENERAL OBJECTIVES

The general objectives of the mental health policy include:

- To improve the mental health of all people in Sierra Leone, particularly the most vulnerable, by increasing access to affordable and acceptable quality mental health services.
- To promote the quality of life (e.g. good general health status, social inclusion) of all people with mental disability and their families in Sierra Leone.
- To develop an enabling social environment for mental health through strong collaboration with all stakeholders, within and beyond the health sector.

SPECIFIC OBJECTIVES

- To provide quality affordable, acceptable and accessible mental health services (including rehabilitation) at all levels as an integrated part of the comprehensive health services package available in Sierra Leone, with a view to achieving a continuum of care.
- To promote mental health and prevent mental disorders (including early interventions and reduction of risk factors) in order to reduce the overall prevalence of mental disorders.
- To promote and protect the rights of people with mental disorders, including by advocating at different levels (e.g. decision-makers, health professionals, communities) to reduce the stigma and discrimination associated with mental illness and by promoting social inclusion of people with mental disorders.
- To foster effective collaborative partnerships and networks for mental health with stakeholders within and beyond the health sector.
- To ensure community involvement and participation in assessing, planning, designing, implementing and evaluating mental health activities at all levels.
- To promote action-oriented research, data collection, monitoring and evaluation in order to inform and support evidence-based mental health practice and services.

- To address the specific needs of special population groups listed in this document when designing mental health interventions and services.

VALUES AND GUIDING PRINCIPLES

Integration of mental health into general health services (holistic model of care and continuum of care): Mental health is indivisible from general health. Both aspects of health are interwoven. A holistic and person-centred model of care which aims at offering continuum of care must integrate mental health services into general health, particularly at primary care level. Integration should happen at all stages, from policy and planning to actual delivery of services.

Decentralization of care, planning and management: Planning and implementation of all mental health activities will be decentralised according to the national policy framework.

Equitable access: Mental health services must be affordable and made available to all as close as possible to people's homes. Users and their families should be involved in the design, implementation and evaluation of services in order to optimize their acceptability, affordability, accessibility and availability with attention to the specific needs of special groups[1].

Quality evidence-based care: Mental health care, including medical and psychosocial care, should be based on the latest available evidence and monitored through quality control mechanisms. Building an enabling and motivating working environment for all health and social workers providing mental health care is crucial for the quality of services.

Promotion and protection of human rights and reduction of stigma and discrimination: The human rights of people with mental disorders and their families should be promoted and protected. People with mental disorders and their families must be empowered and actively involved in the design, implementation and evaluation of mental health services. Monitoring mechanisms must be in place to ensure the respect of human rights in mental health facilities. Stigma and discrimination, often attached to mental disorders, will be fought through advocacy and education, protective legislative and human rights measures.

Community empowerment and active participation: Communities must be actively involved in the promotion, prevention and rehabilitation of people with mental disorders.

Multidisciplinary and multi-sectoral approach: The needs of people with mental disorders are many and cannot be addressed by the mental health sector alone. In addition, addressing mental

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[1] See section 'special groups' (page 25)

health includes many other aspects than treatment of mental disorders and therefore requires the active support and involvement of other health and non health sectors. These partnerships will be crucial to deliver effective interventions for mental health promotion, prevention of mental disorders, rehabilitation and social inclusion of people with mental disorders, which are as important as other treatment aspects in the improvement of the mental health of a population and the quality of life of people with mental disorders.

AREAS FOR ACTION

PROMOTION, PREVENTION, TREATMENT AND REHABILITATION

Promotion and Prevention

Promotion of mental health and prevention of mental illness will take place in collaboration with other stakeholders within and outside the health sector. Every year, the World Mental Health Day (October 10) will be observed with clear mental health messages to the general public. Other events (e.g. World Anti-Drugs Day, World AIDS day, World Human rights day, International Day for the Elimination of Violence Against Women) should be opportunities for mainstreaming mental health messages and reinforcing partnerships.

Mental health messages will also be included in related public health programmes (e.g. maternal health, postpartum psychosis, postnatal depression and impact on children's development). Promotion of mental health and prevention of mental health disorders will be included in school health activities as well as within community interventions.

Treatment

Treatment of mental disorders is primarily the responsibility of the Government. However, the provision of curative mental health services will be done in collaboration with developmental partners, CBO's, NGO's and the private sector. Special attention will be paid to people with co-morbid conditions (e.g. HIV/AIDS or diabetes and mental disorders) so they can receive care and treatment in one place, as far as possible (integration of services), as well as to the specific needs of special groups mentioned at page 26. Treatment guidelines, protocols and standard operating procedures will be developed and adhered to. Collaboration with traditional and spiritual healers in the detection, treatment and follow-up of people with mental disorders will be further explored and researched with a view to define clear roles and responsibilities within the next 5 years.

Rehabilitation

A combination of rehabilitation services will be provided at secondary or tertiary levels by health workers trained in occupational therapy and rehabilitation. In order to prepare the patient for reintegration into the community and family, partnership will be established with community-based and religious institutions. Home visits to counsel and support people with mental disorders and their families will also be promoted.

ORGANIZATION OF SERVICES

The mental health system in Sierra Leone comprises all organizations and institutions that devote their activities to promote, restore and maintain the mental health of the population. These activities include formal health care such as the professional delivery of personal medical attention, action by traditional practitioners, home care and self care, public health activities such as health promotion and mental illness prevention and other health enhancing interventions.

The three traditional levels of care are primary, secondary and tertiary care.

Primary care includes treatment, preventive and promotional interventions conducted by primary care workers. These include the district medical officer, district health sisters, SRN, SECHN, MCH Aides, other healthcare staff, Community Health Officers and non medical staff based in rural areas. Primary care represents the point of entry for most people seeking care and is the logical setting where health problems should first be addressed. Many potential benefits exist for providing service through primary care. Users of primary care are more likely to seek early treatment because of the ready availability of facilities, their easy accessibility, cultural acceptability and reduced cost.

Providing mental healthcare through primary care requires significant investment in training primary care workers to detect and treat mental disorders. Such training will meet the specific practical training needs of different groups of primary care workers. Professionals such as doctors, nurses and community health workers will preferably receive ongoing training to provide subsequent support for reinforcing new skills. Health professionals, having received training in mental health, will be responsible for providing training in mental health to and supervising other health professionals at lower levels (DMOs will train DHMT and district nurses and CHOs with mental health training will train PHU staff in mental health). Primary health care workers/staff will be empowered in their ability to adequately diagnose and treat non-complicated mental disorders. The DHMT in collaboration with NGOs, faith-based organizations and traditional healers will provide community-based care services to the district.

Secondary care is for the management of acute and/or severe cases and patients requiring access to diagnostic and technological expertise. Mental health services will be made available in

regional Hospitals that form part of the general health system. Common facilities will include inpatients beds in the general wards for mental health patients in the absence of specialized wards. Other services offered will include outpatient services, emergency care, multidisciplinary health care and rehabilitation. These require adequate numbers of general as well as specialist professionals who can also provide training and supervision to primary care staff working in the same region.

Tertiary care is the most specialised form of management and is undertaken in teaching hospitals. These facilities are not expected to deliver primary health care but serve as referral centres. They will also be used for postgraduate training and clinical research. Care at this level will be dedicated to the treatment of acute, complicated and severe mental disorders.

ESSENTIAL MEDICINES
To ensure sustainable availability of safe medicines for the treatment of mental disorders, the following activities will be carried out:

- Selection and quantification of the medicines needed for the treatment of mental disorders by an appropriate team of professionals at national level
- Revision of the national essential medicines list to include psychotropic medicines
- Procurement of medicines and supplies for mental health will follow national procurement procedures
- Ensure proper storage and distribution of medicines through strict medical stores procedures
- Promotion of the rational use of medicines for the treatment of mental disorders
- Collaboration with the pharmacovigilance department to monitor quality and adverse side-effects (certification systems)

HUMAN RESOURCES AND TRAINING
Human resources and training issues need to be considered in the short, medium and long-term. Mental health training will be integrated into the general health training programs (doctors, Community Health Officers, nurses including midwives, social workers, etc.) so as to ensure sustainability, accessibility, early detection and continuum of care. Specialized training programmes such as mental health nursing, psychology, psychiatric medicine will be established where possible. Continued education on mental health (e.g. through in-service refresher courses) will be made compulsory for all health care professionals at all levels. Thus, in conjunction with the training institutions, mental health curricula, both for general and specialized health workers, will be developed/revised to include the following:

- ethics & code of conduct

- mental health legislation (Mental Health Act)
- child and adolescent mental health
- women's mental health (e.g. post natal depression, post partum psychosis, violence and abuse)
- prescription guidelines
- non-medical interventions
- emergency situations and mental health
- substance abuse

Key activities for human resources

In the short term (6 months to 2 years)

• Recruit psychiatrists[2]/neurologists, psychiatric nurses (and psychologists if possible) for national and district mental health units (clinical services and training) from abroad (but preferably nationals) through cooperation/agreements with UN agencies, professional associations, NGOs, the Sierra Leonean Diaspora or South-South collaboration. These specialists will provide clinical services, actively participate in designing training curricula for different types of health workers to be involved in mental health care at all levels (national to community-based) and conduct training at national and district levels;

• Develop training resources (curriculum of both in-service and pre-service training, and training of trainers) and training centres throughout the country;

• Refresh and update training of the mental health staff currently working in the Sierra Leone psychiatric hospital (2 psychiatric nurses and about 25 mental assistants), including through shared/joint consultations with a newly recruited mental health specialist.

• Start training general health care workers (community health officers and nurses) to become specialized 'medical assistants - mental health' (2 years post-graduate diploma) and psychiatric nurses (18 months post-graduate diploma), to work in the national and district mental health units;

• Identify and train a core team of trainers in mental health for Community Health Officers (CHO), Primary Health care Unit (PHU) staff, and social workers at all levels.

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[2] Specialized doctors recruited can also be neurologists or neuropsychiatrists, as mental health clinical services described in this policy will address a broad spectrum of psychiatric (e.g. psychosis, depression) and neurological (e.g. epilepsy) conditions.

In the medium term (2 to 5 years)

      • Conduct mental health in service training for CHO and PHU staff in all districts;

      • Encourage medical students and nursing students to enrol in specialist pre-service training, particularly through attractive working conditions (e.g. secured salary, housing allowances or free accommodation, improved quality of services, career development schemes).

In the longer term (5 years and beyond)

      • To keep training in mental health and retaining both specialized and general health staff (including psychologists) and social workers.

LEGISLATION AND HUMAN RIGHTS

A committee comprised of legal luminaries and other stakeholders will set up and review the Lunacy Act with emphasis on making it more humane to meet the demands of present day society (Lunacy is to be replaced by 'mental health'). The revision of the 'Lunacy Act' will also need to be informed by the analysis of some other relevant laws (e.g. The Pharmacy and Drugs Act 2001) so the new 'mental health Act' can address overlapping issues that require updating, such as the definition of the type of health professionals authorized to prescribe and provide psychotropic medications to patients. The revision of the mental health legislation will be complemented by mental health promotion and prevention activities in communities.

People with mental health problems and their families must be informed about their treatment and rehabilitation and must have liberty to give consent to their care or management. Clinical guidelines, including management of relationships with families and patient's environment, confidentiality issues and informed consent, among other important issues will therefore be developed. Emphasis will be placed on voluntary admission, with involuntary admission only being done in exceptional circumstances and being regulated by the law.

The mental health act will be included in the curriculum and training of mental health professionals and other allied disciplines such as social workers and Community health volunteers. Education about the content and application/implementation of the mental health Act and its impact on practice will be emphasized.

ADVOCACY

Advocacy as a tool will be used to:

- Maintain mental health high in the national health agenda
- Support the revision of legislations and include mental health objectives in other plans such as Poverty reduction Strategy Papers (PRSP), HIV/AIDS, Reproductive and Child Health (RCH), etc.
- Give specific attention and resources for mental health
- Reverse the stigma and discrimination associated with mental disorders and promote social inclusion and human rights of people with mental disorders
- Support the paradigm shift from institutional to community/family based mental health care services at all levels for sustainability, accessibility, acceptability and affordability of services
- Increase access to mental health services
- Promote an enabling and motivating work environment for all mental health workers

COORDINATION

Mental health activities will be jointly coordinated by the Ministry of Health and Sanitation; Ministry of Education, Youth and Sports; Ministry of Social welfare, Gender and Children's Affairs; Ministry of Local Government and Rural Development; and Ministry of Justice. The Ministry of Health and Sanitation will play a lead role in the coordination of mental health services through the Directorates of Post graduate training, Non-Communicable Diseases and Research (PNR), Primary health care (PHC), and Hospital and laboratories (H&L). H&L coordinates health care at tertiary level and PHC at secondary and primary levels.

There will be joint annual planning and quarterly reviews with the District Health Management Teams (DHMTs). The directorate of PNR will supervise the development of an updated database of the different mental health providers and stakeholders at country level, while at district level, District Health Management Teams will be responsible for developing and updating such a database.

Mental health activities will be implemented at district level by the responsible DHMT. The Districts will report to the central level.

A mental health coordinator within MoHS/DPNR shall be appointed full time to oversee activities of the mental health unit which includes technical and administrative duties, to advocate for mental health and to coordinate the implementation of the policy and plan with other relevant Ministries, UN and bilateral agencies, NGOs and civil society. The mental health coordinator will be knowledgeable in mental health, have excellent communicating and interpersonal skills as well as a good understanding of policy, planning, and public health priorities in the context of Sierra Leone. The mental health coordinator will be expected to

develop partnerships and advocate for mental health within and beyond the government. The unit will also have an administrative assistant.

The mental health unit will be adequately resourced to function effectively and will be supported by a team of technical and administrative experts (the mental health advisory group) which will be selected by the Chief Medical Officer in consultation with the Top Management Team of the MoHS. The unit will have adequate space, access to meeting rooms and basic resources such as computers with internet access and a photocopier. It will also have a budget for personnel and administrative expenditure. The Directorate of PNR through the mental health unit will be responsible for policy, planning, oversight, monitoring and evaluation functions.

INTERSECTORAL AND INTRASECTORAL COLLABORATION

As factors influencing the mental health of the population cannot be fully addressed by the health sector alone, cross cutting collaborative efforts are key to a successful national mental health strategy. Health and International development partners, both at inter and intra-sectoral levels, play a pivotal role in provision of technical and financial support for health in general and mental health in particular.

Intra-sectoral relations to be developed include:

- Maternal and child health: integration of a mental health training component in health promotion, prevention, clinical and psychosocial interventions.
- Health education: mental health promotion and prevention, including school interventions and school counselors.
- Adolescent health: adolescent counseling centers, mental health promotion and prevention components in adolescent health interventions.

Inter-sectoral relations to be developed include:

- Ministry of Finance and Economic Development: financial and logistic support to implementation.
- Ministry of Education, Youth and Sports: development of mental health curriculum; support to mental health promotion and prevention; support in mental health training and enhancement/scaling up of school counselors program.
- Ministry of Social Welfare Gender and Children's Affairs: provision and posting of social workers; development of mental health curriculum for social workers; support to specific provisions/interventions for special populations; support to psychosocial component of mental health interventions.

- Ministry of Agriculture and Food Security: support to rehabilitation programs (incl. employment) and agriculture extension support.
- Ministry of Internal affairs and Local Government: funding and implementation of the mental policy and plan at district level.
- Ministry of Information and Communication: advocacy and mental health promotion.
- Police Force, Armed Forces, Prisons: support to mental health training of prison health workers and sensitization of police and armed forces officers;
- Ministry of Justice: support to the revision of the 'Lunacy Act' and support to mental health sensitization of law officers.
- National Drugs Law Enforcement Agency: liaison and support to the development of a substance policy and plan.
- Ministry of Labour and Employment: support to rehabilitation programs (incl. employment for people with mental disabilities).
- Ministry of Lands, Housing and the Environment: support to rehabilitation (incl. employment and housing) programs and support to provision of accommodation for mental health workers;

Collaboration with other agencies

- UN agencies, funding agencies, International NGOs: financial and logistic support to implementation; as well as mainstreaming of mental health issues into all relevant health and development programmes
- National NGOs, CBOs in health sector: financial and logistic support to implementation; advocacy.
- Private initiatives in health sector: financial and logistic support to implementation.
- Directorate of drugs and medical supplies: logistic support to psychotropic medicines procurement, distribution and management.

OPERATIONAL RESEARCH

Operational research will be supported to inform evidence based treatment and policy changes. Priority research areas will be the following:

- Health seeking behaviours (factors influencing);
- Beliefs systems and explanatory models for mental disorders;
- Traditional medicine: practices and classification of practitioners (e.g. spiritual healers versus herbalists), efficacy of herbal treatments;
- Impact of substance abuse on mental health (and reciprocally);
- Impact of domestic violence on mental health;
- Evaluation of mental health services; policy evaluation.

QUALITY IMPROVEMENT

Health Care workers must undertake two key functions to provide good quality care for mental health at all levels and these include:

- Assessment and diagnosis of mental disorders
- Treatment, support, including rehabilitation, referral and prevention services

To perform these functions, mental health care workers require good communication skills and adequate education on mental health issues during pre-service education, internship and residency as well as in-service training in the form of short courses, continuing education, and on-going supervision and support. It is essential that the quality of mental health services is improved and maintained. High quality care means that the latest evidenced-based interventions are provided for mental health services at all service levels. It also refers to a quality improvement monitoring mechanism, involvement of users and families, etc. Care protocols and basic quality standards for services will be developed at all levels of care.

INFORMATION SYSTEM

The information system will aim to improve the effectiveness and efficiency of the mental health services and its equitable delivery to enable managers and service providers make well informed decisions that improve the quality of care.

Key mental health indicators will be developed and integrated into the already existing Health Management Information System (HMIS) of the country. This will require reviewing and adaptation of patient record forms. Health care staff will be trained to collect, process, analyse, disseminate and utilise information at the various levels of service.

FINANCING

There is already a budget line for the financing of the Sierra Leone psychiatric hospital. Key directorates such as the Postgraduate training, Non-Communicable diseases and Research (PNR), Primary Health Care (PHC) and Hospital and Laboratories (H&L) at central level and District Health Management Teams (DHMTs) at district level will integrate mental health activities within their annual activity plan and budget.

Central level will review mental health policy, strategic plans and guidelines and provide support in their implementation at district level. Central level will also advocate for an increase in the mental health budget at district level. District Health Management Teams will finance and operationalize the mental health strategic plan. Consequently, the district budget for mental health will increase to accommodate these new activities.

An effective mental health programme will require adequate and sustained financing for infrastructure, technology, supplies (medicines), service delivery, development and remuneration of a trained workforce. The Directorate of Non-Communicable diseases will ensure that central and district plans include a budget for all mental health activities and needs. The budget will include initial investment for training and recruitment. As there is solid evidence that mental disorders represent at least 13% of the total burden of disease and 31% of all health-related disabilities in Sierra Leone as well as worldwide, the MoHS will increase the mental health budget.

The Ministry of Health and Sanitation, through the Directorate of Non-Communicable Diseases, will commit to accessing other sources of funding to meet the challenges of implementing mental health activities outlined in the policy and plan. The resources will be mobilized from donors through technical cooperation, bilateral and multilateral partnerships.

The long term aim is to have mental health covered in the national social and health insurance scheme, which is about to be implemented at national level. However, all health services (including pharmacological treatment for both mental and physical disorders) will be provided free of charge to people with severe mental disorders, as they fall under the category of 'vulnerable group/people with disabilities' within the new national health policy framework (*Sierra Leone National Health Policy 2009*).

ACTIONS FOR SPECIAL GROUPS

Particular attention must be given in the design and implementation of mental health services and in the development of strategic partnerships to some special groups who have specific needs.

PEOPLE WITH SUBSTANCE ABUSE DISORDERS

Substance abuse is a highly prevalent problem in Sierra Leone, particularly among the young population. Substance abuse widely overlaps with mental health.

The main strategies adopted to address drug control in terms of prevention, treatment and rehabilitation, should take cognisance of the strong link existing between substance abuse and mental health.

Young people should be a main target not only with the aim of reducing their drug consumption, but also of including them in social and income generating activities.

The huge profit derived from growing certain illegal drugs (nominally marijuana) is a great incentive in its production. Growing marijuana results in ten times more profits than what can be derived from growing rice. In addition, it does not require as much labour, pesticides and waiting time.

Strategic partnerships will be developed between the MoHS, WHO, UNODC, the National Drug Law Enforcement Agency and all relevant stakeholders in this field, particularly in the revision of the national strategy for substance abuse.

PEOPLE LIVING WITH HIV/AIDS

HIV/AIDS has significantly increased the need for an urgent scale-up of comprehensive mental health services that work in collaboration with national and local AIDS programmes. Particular attention must be given to the needs of care givers, people living with HIV/AIDS and children affected by HIV/AIDS - groups identified as often experiencing the most significant mental health challenges as a result of AIDS.

People affected by HIV/AIDS are more prone to developing mental disorders such as depression (one in three persons with HIV/AIDS has depression, as estimated by SAMHSA[3]), anxiety and stress which, in turn, impair their immune function, reduce their quality of life and adherence to treatment and contribute significantly to their premature deaths. Some opportunistic infections affect the brain and the nervous system. In addition, antiretroviral therapies can have mental or neurological side-effects.

HIV-positive individuals cope with unique stresses of facing diagnosis, the often related discrimination and consequences both in their private and socio professional life as well as the

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[3] http://download.ncadi.samhsa.gov/ken/pdf/FastFacts/FastFact4.pdf

difficulty of sharing their status with others. They may also be affected by HIV-related mental health conditions such as HIV-associated dementia. HIV status is an important factor in determining appropriate treatment for mental illness.

Caregivers also experience high levels of stress and their role can take a substantial mental and physical toll on their health as they care for the physical, emotional and economic needs of their family members.

There is a need to better understand how mental health problems increase the vulnerability of individuals to HIV infection and the need to train health care workers in order to reduce the mental health and HIV related stigma.

MOTHERS AND CHILDREN

Mental health problems during pregnancy and after childbirth are common. They both significantly contribute to maternal mortality and severely impact on children's development. There is a need for prevention and early detection of mental disorders during pregnancy and after childbirth, in collaboration with the relevant partners.

Prevalence rates of mental/psychiatric disorders have been found to range from 12% to 29% among children visiting primary health care facilities in various countries. Specific mental disorders, including epilepsy, occur at certain stages of child and adolescent development, often as a result of complications during pregnancy and childbirth. Screening programs and interventions can therefore be targeted to the stage of fetal development, delivery and childbirth. Besides, early intervention (in childhood) can prevent or reduce long-term impairment as there is a high degree of continuity between child and adolescent disorders and those in adulthood. For example, early treatment and stabilization of epilepsy will allow a child, at limited cost, to live a normal life and to avoid unjustified discrimination and injuries (as a result of seizures).

70-80% of women with maternal mental disorders can be successfully treated and 70% of people with epilepsy could become seizure free with appropriate antiepileptic treatment.

A very positive message is that to a large extent the identification and management of most of these mental disorders can be done at primary health care level, by first line interveners, incorporated into primary health care routines.

PEOPLE IN PRISONS

Mental Health can be affected by life in prisons. Here, many factors may have negative effects on mental health, including: overcrowding, various forms of violence, enforced solitude or conversely lack of privacy, lack of meaningful activity, isolation from social networks, insecurity about future prospects (work, relationships, etc), and inadequate health services - especially mental health services - in prisons. The increased risk of suicide in prisons (often related to depression) is one common manifestation of the cumulative effects of these factors.

In Sierra Leone, there are 15 prisons in use and they do not have the facility, including appropriate medicines, and the trained personnel to care for inmates with mental disorders.

A crucial issue is overcrowding in all prisons in the country. In Freetown, the prison was constructed for 430 inmates, and now holds over 1200 inmates. Availability of illicit drugs within the prison is also a major concern for inmates' health and security.

Mental health within prisons might be dramatically improved by specific actions, such as:
- Recruiting and training nurses in mental health
- Establishment of a counseling department
- Providing incentives for medical staff in order to facilitate the recruitment and retention in a difficult working environment
- Addressing availability of illicit drugs by tightening control while offering appropriate care for inmates facing withdrawal syndromes
- Providing health workers with basic psychotropic drugs
- Strengthening the referral system while promoting the management of people with mental disorders within prisons whenever possible

VICTIMS OF VIOLENCE AND ABUSE

All stakeholders mentioned during consultations the importance of paying particular attention to the specificities of persons who have been victims of violence and abuse. More than 90% of the population in Sierra Leone has been exposed personally to some form of violence over the past years. This can include various forms of violence, from physical and/or sexual abuse perpetrated during the conflict to mutilations, child abuse, human trafficking, commercial sex workers, and domestic violence among other forms of violence.

A minority of victims of violence and abuse may develop severe chronic psychological distress and dysfunction suggesting mental disorders, which should be recognized and appropriately treated within the general health system.

Appropriate treatment will include not only psychopharmacological treatment but also psychological and social support.

Partnerships with relevant stakeholders should be developed for prevention, support/treatment and rehabilitation of the psychological consequences of these different types of adversity.

MONITORING AND EVALUATION

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 long term service and policy related decisions and changes.

The implementation of the policy via the strategic plan will be evaluated on an on-going basis through 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 the strategies will be assessed in terms of whether targets and indicators for each have been achieved. At the end of the policy period the plan will be evaluated for its relevance and appropriateness as well as the degree to which each of the policy objectives have been met.