REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

NATIONAL POLICY FOR MENTAL HEALTH

CHAPTER 1:   INTRODUCTION

1.1 Background

Mental illness affects everybody regardless of race, colour, gender, age or nationality. Some mental illnesses can be cured, while other conditions can be rehabilitated to sustain life and improve the quality of life. Outcome of treatment depends on early detection and intervention, proper follow-up and rehabilitation. There is cure for some conditions and long-term treatment is the rule for others. Some mental illnesses can be prevented to avoid loss of life and huge cost on chronic psychosocial disability.

Studies done in several parts of the world have shown no significant intercultural differences in the range of mental health problems. Such studies indicate that approximately 2-3% of the population at any one time suffer from seriously incapacitating mental disorders; approximately 10% have common mental disorders. This group accounts for 20-30% of those attending primary health care (PHC) services. They tend to visit curative health services repeatedly and take up a disproportionately large part of the health workers time (WHO, 2001).

Mental health services in Namibia lag behind other health services. This pattern is similar to many other developing countries where mental health often receives low priority. Pressed with limited resources, health policies are directed towards the communicable and life threatening diseases. Mortality is taken as the yardstick for priority selection. However, recent studies and recommendations of WHO have shown the importance of both disability and mortality in assessing health priorities (Murray and Lopez, 1996; WHO, 2001). Measures of disability and mortality combined show the significant level of disability created by mental disorders and the enormous economic, social and psychological burden imposed on families of people with mental disorders. These findings emphasise the need for governments to take mental health seriously as a major public health issue. This includes the promotion of mental well-being, prevention of mental illness and disability, treatment and rehabilitation.

Following independence in 1990, the Government of the Republic of Namibia extensively restructured the health services. The guiding principles for this process were equity, accessibility, affordability, community involvement and participation through the Primary Health Care (PHC) approach. The goal was and remains Health For All Namibians. However, this goal cannot be achieved without developing a network of health services that include mental health care with outreach to the community. With recent evidence of the significant and growing burden of mental disorders, and WHO recommendations to address mental health as a major public health issue, mental health services needs to be strengthened and integrated into the network of health services offered.

This mental health policy addresses the major mental health issues facing Namibia. It defines the approaches that must be made for intervention. The basis of the mental health policy is the promotion of mental health the extension of services to communities and families and the protection of the rights of people with mental disorders. Management of mental health problems involve multi-sectoral action and support by the relevant ministries, non-governmental organizations, private and traditional sectors. Therefore it is important to strengthen partnerships and networking among these key players and stakeholders at all

stages of the development. It is equally important to review the current Mental Health Act in line with this policy.

1.2. THE METHODOLOGY FOR POLICY DEVELOPMENT

The compilation of this policy has followed a number of important steps.

A mental health needs assessment was done in 1996 to collect basic data. This undertaking was followed by a situation analysis tour to a number of regions where mental health issues were discussed with the health care workers in the field. Literature on mental health problems and policy issues was also reviewed. The first draft of the policy was then compiled and distributed to the regions for comments. A workshop, with participants from all the regions and other stakeholders, was then conducted. Input from all participants was incorporated into the draft. The document was presented to the Primary Health Care Directorate Management Committee, before submission to the Policy and Management Development and Review Committee for approval. The document was referred back for revision on two subsequent occasions for further improvements, which were instituted with assistance from Health and Social Sector Support Programme (HSSSP), the document was developed further. In 2004, with technical assistance from WHO, a further workshop was conducted with stakeholders from a range of ministries and other agencies to finalize the policy. The document was then submitted to the Policy and Management Development and Review Committee for final approval.

CHAPTER 2: SITUATION ANALYSIS

2.1. The Global Burden of Mental Health Problems

Mental disorders accounted for approximately 12% of the Global Burden of Disease in 2000. It is anticipated that this will increase to 15% by the year 2020. Five of the 10 leading causes of disability worldwide (major depression, schizophrenia, bipolar disorders, alcohol abuse, obsessive compulsive disorders) are classified as mental disorders. Depression will be the second leading cause of health disability in the world by 2020, second only to ischaemic heart disease (Murray & Lopez, 1996). These mental disorders are as significant a burden in developing nations as they are in developed nations (WHO, 2001).

In developing nations, poverty, rapid socio-cultural, technological and political changes, in addition to overcrowding, unemployment, rural-urban migration and lack of modern health care facilities make mental health a major health problem. The process of development itself produces problems of adjustment and adaptation with serious mental health consequences. Mental health problems may present in various ways, such as physical complaints, criminal offences, suicidal ideation, suicide, absenteeism from work, school dropouts, drug dependence, delinquency, and so forth. While these problems are serious enough in themselves, they also cause suffering to the family and have serious social and economic consequences to the community.

2.2. The Burden of Mental Health Problems In Namibia

The mental health data available do not adequately reflect the nature and magnitude of mental health problems in Namibia. However, the general overview about mental health problems as stated above, applies also to Namibia. While an estimate of the magnitude of mental health problems can be made from studies done in other countries with similar socio-economic levels of development, it is very important to undertake such studies in Namibia.

Namibia has been negatively impacted by the colonial political system, and the apartheid system of racial domination and oppression. Many years of the liberation struggle, which was accompanied by major psychological stressors have important implications for the poor state of the nation's mental health. High rates of unemployment (currently at 35%) increase the risk of mental disorders in the community.

In 1996, the mental health program conducted a needs assessment. This study reported that dependency on alcohol, tobacco and other drugs was on the rise. Drug induced mental disorders are therefore a major concern. The individual, family, community and the nation at large are all negatively impacted by substance dependency. In particular, domestic and sexually related violence have been reported in the media and have been linked to substance abuse, especially alcohol.

Recent increase in the rate of suicidal ideations and suicide in Namibia have caused a great deal of concern. There appears to be a shift toward the younger age group especially with regard to the increase in the suicide rate.

HIV/AIDS is increasing at an alarming rate. In 1997, AIDS was the number one killer in Namibia, killing more people than malaria and tuberculosis (TB) combined. It is estimated that AIDS has already orphaned at least 31,000 children in Namibia leading to serious physical, psychological and social trauma (First National Conference on Orphans and Other Vulnerable Children, Full report 2000).

In 1992, a demographic and health survey was conducted. This survey found that the disability rate in Namibia was 3.1%, of which 7,360 (15 %) were people registered as living with mental health problems. The 2001 Population and Housing Census reported that 5.6% of those living with disability suffered from a mental disability.

The Health Information System Report (2001) data released by the Ministry of Health and Social Services, reveal the following pattern: 1.52% (42,124 people) who were treated at outpatient clinics carried a mental health diagnosis. 3.37% (40,940 people) who revisited the outpatient clinics were admitted under the diagnostic category of mental health disorders. 3.8% (4,182 people) of all people treated at the inpatient level were discharged with a mental health diagnosis, ranking this condition as number twelve (12) of all twenty-five (25) discharges.

These figures are likely to be an underestimate as the health workers in the survey frequently did not have training to detect the many patients who report to the clinics with mental disorders, many of which present as ill-defined physical symptoms.

A conservative estimate of the number of mental health problems in need of some kind of mental health intervention, at any given point in time, would be as follows:

- Adults with serious mental disorders: 21,500 - 32,500 (2-3% of adult population).
- Adults with common mental disorders: 108,313 (10% of adult population)
- Children with serious mental health problems: 3,600 - 7,200 (0.5-1 % of children below the age of 15 years).
- Children with learning or behavioural problems: 6,600 (1% of children below the age of 15 yrs).

The statistics reported above are based on the projected population of Namibia, which was 1,805,227, in 1999 and of which 60 % were adults and 40 % children below the age of 15 years.

The above figures do not take into account the HIV/AIDS related mental health problems. It is widely accepted that there is an increased risk of mental disorders among people who are HIV positive. This includes both "organic" mental disorders such as AIDS dementia, and the psychological sequealae of living with HIV, such as depression, anxiety and suicide. The above figures also do not include alcohol-related mental health problems.

In conclusion, the need for mental health interventions is very great, and yet there is no concerted effort to reduce the burden, at the present time.

2.3. Mental Health Services

2.3.1 Administration

The national Mental Health Programme is a unit within the Disability Prevention and Rehabilitation Division under the Primary Health Care Directorate. Its functions are policy formulation, strategic planning, technical-support to all levels, implementation, monitoring and evaluation of the mental health activities. This includes planning for human resource training. Qualified psychiatric nurse currently heads the Mental Health Programme. The establishment of this unit provides the foundation on which future mental health services can be built. The Mental Health Programme works in partnership with the Alcohol and Substance Abuse programme in the Social Services Directorate.

2.3.2 Services

Mental health services are currently available at the following institutions:

- Windhoek Mental Health Care Centre (National Referral Hospital)
- Oshakati Psychiatric Unit (Intermediate hospital)

Emergency mental health services are also provided at district hospitals as part of general wards. There are no specialist mental health staffs in these facilities. Follow up and a limited range of psychotropic medications are available at some health care centres and clinics. The available medications are specified according to the NEMLIST.

The Windhoek Mental Health Care Centre is a department under the Windhoek Central Hospital. This Centre provides outpatient and inpatient services to adults and children, with a bed capacity of one hundred and twelve (112). The Forensic Service Unit is located in the same Centre and has ninety-nine (99) beds. The Centre has the full range of professionals, but their numbers are insufficient.

The Oshakati Psychiatric Unit, which is located in the Oshakati Hospital has eighty (80) beds, but admits up to ninety (90) patients. There is a large outpatient clinic that provides service to a minimum of 100 patients per day. This unit has one psychiatrist and does not have a clinical psychologist or occupational therapist. The specialized staffs are therefore not sufficient.

Private practitioners also provide mental health services (10 psychologists, 3 psychiatrists) in Namibia, but these services are limited to those who can afford them. Doctors, nurses, psychologists and occupational therapists in private practice refer some clients and patients to the mental health care unit in Windhoek.

The number of those individuals suffering from mental disorders who seek the services of traditional healers is unknown. There is, however, a need to study the types of traditional healers and the methods they use in Namibia, before an intelligent decision can be made as to the benefits derived from their interventions, as well as,

possible areas of collaboration. In the mean time, it is important to maintain a good working relationship with traditional healers.

At present the referral system is not well established. Patients from outside Windhoek are first handled at their nearest health facilities. The responsible doctors follow referral guidelines sent out to all regions by the psychiatrist. According to these guidelines, the patient should first be treated for at least 72 hours in the service at which they present. After 72 hours if there is no improvement in the patient's condition, the doctor should refer the patient to the psychiatrist. However, there are still problems experiences in the referral system, because the health professionals at the peripheral level are not sufficiently skilled and lack the competence to handle the mentally ill patients. In general, the referral system is not well established and qualified mental health professionals are scarce.

In conclusion, specialized mental health services are available at the Windhoek Mental Health Care Center and Oshakati Psychiatric Unit. Some services are also provided at the district hospitals. Currently services are not community-based and inadequately integrated into primary health care.

2.3.3 Availability of Psychotropic Medication

Psychotropic medication in Namibia is made available, according to the Namibian Essential Medicines List (NEMLIST). The list has a sufficient range of drugs for the treatment of the mentally disordered individuals who require medication. These drugs are available through district hospitals.

2.3.4 Mental Health Legislation

Mental health services are provided under the Mental Health Act, Act no 18 of 1973. The Act is considerably outdated with regard to many aspects. A new Bill is in the early stages of development. This is an essential element of reform that is needed as part of the implementation of this policy.

2.4 Consequences and Implications of the Current Situation

From the available data it is estimated that only a small percentage of mentally disordered individuals are receiving appropriate evidence-based mental health services. This situation is attributed to various factors, but the most important ones are listed below:

- Lack of skilled health care professionals
- Inability to accurately diagnose mental disorders
- Inaccessibility of available services
- Ill-informed belief systems about the causes, as well as the treatment of mental disorders
- Lack of follow up and after care
- Lack of rehabilitation programmes and facilities
- Lack of knowledge regarding mental health among key decision-makers
- Lack of regional level management representation for mental health

• Lack of up-to-date legislation

Treatment outcomes of mental health services depend on early detection and intervention, as close to home as possible and with the involvement of the family. To achieve successful outcomes, there is a need to decentralize and integrate the mental health services into the existing primary health care systems, as well as to develop community-based services. These services can be delivered with the right quality and quantity of human resources, improved referral systems and allocation of proportionate financial resources.

CHAPTER 3: POLICY FRAMEWORK

3.1 Policy Goal

The goal of this policy is to achieve and maintain a high standard of mental health and well being in the population of Namibia, and to reduce stigma against people with mental disorders. This is to be achieved through the development of a comprehensive community-based mental health service that is decentralized and integrated into the general health service.

3.2 Policy Guiding Principles

3.2.1 Mental health services should be comprehensive and should offer a range of interventions in keeping with evidence-based care.

3.2.2 Mental health services should be integrated with the existing health care **and social welfare** system so that mental and physical health needs are equally met.

3.2.3 Mental health services should be community-based, equitable, accessible, affordable and acceptable to the people.

3.2.4 People with mental disorders should be cared for **by their families, communities and when necessary in** facilities with the least restrictive form of care.

3.2.5 A range of sectors should be involved in mental health including, but not limited to: health, **social welfare,** education, justice, prisons, police, land, housing, NGOs, religious organizations, the private sector and the community at large.

3.2.6 The full human rights of people with mental disorders should be promoted and protected and stigmatisation of a discrimination against the mentally ill should not be tolerated.

3.2.7 The establishment of advocacy and support groups at the community, regional and national levels to empower people suffering from mental disorders should be encouraged.

3.3 Policy Objectives

3.3.1 To establish an appropriate legal framework that protects the rights of people with mental disorders, promotes mental health, **prevents** disorders and ensures appropriate services for treatment and rehabilitation.

3.3.2 To develop a comprehensive, decentralised, community-based mental health service for the population of Namibia, integrated into the existing health **social welfare and community** system

3.3.3 **To insure that all human resource involved in the programme have** appropriate mental health training and orientation to the new mental health policy and programme.

3.3.4 To develop and sustain information and monitoring systems to continuously oversee the quality of the mental health service and the implementation of the mental health policy.

3.3.5 To encourage active collaboration between all sectors involved in mental health, including **strong** community **participation** in mental health.

3.3.6 To actively promote mental health in the community through information, education and communication strategies.

3.3.7 To develop community-based residential facilities for people with mental disorders.

3.3.8 To develop and sustain comprehensive mental health services for children and adolescents.

3.3.9 **To initiate research on** important mental health issues.

3.3.10 To recruit and retain a high quality mental health workforce.

3.4 The Policy Strategies

The following key strategies have been identified, to achieve the above objectives, in order of priority.

3.4.1 Development of guidelines for the implementation of the mental health programme at all levels

3.4.2 Review of the existing mental health legislation.

3.4.3 Orientation of all personnel to the Mental Health Policy and Programme.

3.4.4 Development of a mental health training component during the undergraduate training for all health workers, in-service training in mental health for all health workers and Continuing Professional Development (CPD) for mental health **professionals.**

3.4.5 Development of decentralized mental health services that are integrated with the existing health services through PHC, including established referral systems and outreach to the community.

3.4.6 Development of a simple and up to date mental health information system integrated into the existing HIS, using standard classifications.

3.4.7 Collaboration and co-operation with general health workers and partners in the community such as community leaders, traditional healers, teachers, law enforcement agencies, development agencies and NGOs.

3.4.8   In collaboration with other health workers, develop appropriate mental health IEC strategies to sensitize the community to mental health issues. This includes using mass media, group discussions and **one- on- one communication covering aspect of** positive life styles, the causes and treatment of mental health problems, early signs and symptoms of some mental illnesses, health education about alcohol, tobacco and other substance abuse, and HIV/AIDS.

3.4.9   Establishing the institutional framework for an inter-sectoral Mental Health Action Group to assist in developing a coordinating mechanism for the promotion of mental health, and the prevention, treatment and rehabilitation of mental illnesses.

3.4.10 **Ensuring the** provision of psychotropic drugs at all levels of health care and at all times, according to the level of responsibility.

3.4.11 Development of a reporting, monitoring and evaluation system for the mental health programme.

3.4.12 **Continuou**s programme review by conducting supervisory visits at regular intervals at all levels.

3.4.13 Development of counseling services for high risk groups such as posttraumatic stress disorder, children, adolescents, older adults, refugees, and those under the stress of the socio-economic and cultural changes taking place in Namibia.

3.4.14 Develop community-based residential facilities such as halfway houses and/or agricultural rehabilitation villages. Rehabilitation programmes should aim at the re-integration of individuals into the community, through collaborative efforts among the families, various **non-governmental and faith-based agencies** and key people in the community. The community rehabilitation health worker should play an important role in this undertaking.

3.4.15 **Ensuring** Human Resource planning and management to **provide for** new posts, **enhance** recruitment **and** retention of staff **and ensure adequate supply.**

3.4.16 To develop comprehensive mental health services for children and adolescents. This will include **mental health promotion and life coping skills training in schools,** strengthening the child and adolescent psychiatric unit in Windhoek and establishing a child psychiatric unit at other referral hospitals. Ministry of Women's Affairs and Child Welfare; Ministry of Basic Education, Sport and Culture; Ministry of Higher Education and the Ministry of Prisons and Correctional Services should be involved in early detection of mental health problems, and promotion of mental health. Collaboration will be strengthened with NGOs and **faith – based** organizations in this respect.

3.4.17 Develop national mental health standards and quality improvement mechanisms to monitor and accredit all mental health facilities, including public and **private facilities.**

3.4.18 **Promote** research in the field of mental health. Reliable information concerning the various communities, mental health problems, community resources, risk factors, and

the most vulnerable groups should be collected for re-assessment and reformulation of policy. Particularly important is research into the mental health consequences of HIV/AIDS. **Research** should focus on epidemiological, socio-economic, cultural **and traditional aspect of causes and** responses to mental health problems.

3.4.19 Collaborate with employers to introduce the mental health policy in the workplace **and support the establishment** of employee assistance programs (EAP).

3.5 Policy targets

CHAPTER 4:

INSTITUTIONAL FRAMEWORK FOR POLICY IMPLEMENTATION

This chapter describes the institutional framework for implementation. The following aspects are being discussed: a) the role and responsibilities of the various management levels within the MOHSS; b) the functions of the various service provision levels; c) the National Mental Health Group; and d) the responsibilities of the various sectors sand stakeholders

4.1   Management Levels:

4.1.1   National level - Programme Manager:
         Senior Health Program Administrator (SHPA)

Responsibilities:

- Plan, develop, **coordinate**, advocate and manage the mental health **programme** of the nation
- Assess the training needs and develop training programmes nation-wide, including developing a mental health training manual for PHC nurses
- Co-ordination with other PHC programmes at national level
- Co-ordination with directorates of MoHSS, other ministries and organizations
- Develop indicators to monitor mental health activities
- Provision of technical support to the regions and districts
- Networking with mental health programmes in neighbouring countries
- Supervision and monitoring
- Establishing an information system to monitor the nationwide operations of the mental health system
- Developing a national quality assurance and quality implementation system to ensure effective service delivery
- Identify and support research activities
- Legislation and regulation
- Policy formulation and strategic planning
- Social mobilization and advocacy
- IEC

4.1.2   Regional level

Division Rehabilitation and Social Welfare Services

Subdivision Rehabilitation
Responsibilities

- Develop and coordinate the mental health programme at regional level.
- Facilitate the integration of mental health programme into Primary Health Care.
- Support and facilitate the translation and implementation of the national policies and legislation on mental health.
- Coordinate and facilitate National events.
- Identify areas with specific training needs in mental health.

- Translating the mental health policy into practical and feasible strategies that can be implemented at Regional level.
- Monitoring and supervising the implementation of the programme at regional and district levels.
- Provide input into the development of IEC materials policies, guidelines and standards for mental health.
- Support and facilitate the establishment of a mental health reporting system.
- Establish and maintain a well co-ordinated and standard referral system.
- Initiate, establish and implement community mental health care services.

Subdivision: Social Welfare Services

Responsibilities:

- In collaboration with subdivision rehabilitation establish support groups. e.g. Alcohol and Drug rehabilitation group, etc.
- Collaborate and cooperate with subdivision rehabilitation to organize national mental health events.
- Organize family counselling sessions.
- Assist to obtain collaterals from families for forensic patients.

Chief Control nurse with mental training
Principle Occupational therapist

- **Outreach and supervision to prisons, with support of RMT.**

4.1.3 District level

The following staffs play an important role in the district mental health programme:

- **Principal Medical officer**
- **District PHC coordinator**
- Medical officers (General **medical practitioner** with mental health training)
- Registered Nurses (with mental health training)
- Enrolled Nurses
- Medical rehabilitation workers/occupational therapist.

Responsibilities:

One member of the District Coordinating Committee (DCC) should receive professional training in mental health care and service planning.

The responsibility of the DCC will be to:

- Provide **service** and facilities for admission and seclusion of patients with mental disorders, which respect the human rights of patients
- Oversee the mental health **programme within the district**

- Staff development and continuous education, in order to empower the health care professionals with regard to symptoms recognition, diagnoses, and management of mental disorders
- Monitoring and evaluation of the **district** mental health programme.
- **Ensure the provision and development of** community **mental** services by a community team.

4.2 Services Providers

4.2.1 The National Hospital:

<u>Responsibilities:</u>

Windhoek Mental Health Unit will provide the following mental health services:
- Tertiary treatment and referral centre for specialised mental health services
- Training and supervision for mental health nurses and other health care professionals
- Mental health research in collaboration with other institutions and the University of Namibia
- Forensic psychiatric services.
- Specialist outreach services to intermediate hospital and regions;
- Community outreach by a team comprising occupational therapists, social workers and nurses
- The staff of the centre shall play a major role in the implementation of the national mental health training programme and in the provision of support to the lower level mental health services units

4.2.2 The Intermediate Hospitals:

<u>Responsibilities</u>:
- Mental health treatment and receiving of s referrals from the regions and districts which they serve
- Training of mental health nurses and other health care workers
- Making referrals to the tertiary level for specialized treatment
- Capacity building of mental health workers at regional and district levels
- Reporting on mental health activities, based on specific indicators to the national level
- Supervision **of a**nd support to district hospitals
- **Implementation** of mental health research in collaboration with the Windhoek Mental Health Unit, other research institutions and the University of Namibia (UNAM)
- Outreach services to the surrounding communities
- Forensic psychiatric services
- Keep accurate patient records and collect information for the Mental Health Information System

4.2.3 The District Hospitals:

The functions of the district hospitals will be the following:

- Diagnose and treat mental disorders

- Provide facilities for admission and seclusion of patients with mental disorders, which respect the human rights of patients
- Refer patients to higher levels of care, when there are difficulties pertaining to accurate diagnosis and/or management
- Provide follow-up outreach for patients referred back from tertiary or regional mental health services, and manage patients referred from health centres and clinics
- Staff development and continuous education, in order to empower the health care professionals with regard to symptoms recognition, diagnoses, and management of mental disorders
- **Community outreach services**
- Keep accurate patient records and collect information for the Mental Health Information System.
- Work with local individuals such as community leaders, teachers, police, other health workers, development agencies, traditional healers and non-governmental organizations for the promotion of mental health, as well as the prevention, treatment, after care and rehabilitation of the mentally challenged individuals

4.2.4   Health Centres and Clinics:

4.2,.4.1 Health Centre Level

- Ensure basic health services which provide equal opportunities for both the physically and mentally ill patients
- Detect children with learning difficulties and children suffering from depression, anxiety, attention deficit, hyperactivity disorder and conduct disorder, and child abuse make referrals to special education programs, if and when available
- Provide health education about alcohol and other addictive substances
- Treat emergency cases of grand-mal epilepsy, refer, and follow up
- Treat emergency cases of acute psychoses, refer, and follow-up
- Provide after care to patients and monitor their medication regimens
- Provide home-based **care** services to support the family and the patient
- Maintain good record keeping about psychiatric admission, treatment interventions, follow up, and discharges
- Provide mental health education to patients and their families as well as to the community at large.

4.2.4.2 Clinic Level

- Ensure basic health services, which provide equal opportunities for both the physically and mentally ill patients
- Promote healthy life styles and positive mental attitudes, as well as coping mechanisms
- Detect mental disorders among patients who attend clinics, offer basic counselling and refer complex cases
- Provide follow-up and after care of discharged patients, including home visits, as well as making sure that relevant medication is available at the clinic
- Develop inter-sectoral and community involvement, including schools, healers etc. to ensure better mental health **amongst communities**
- Keep patient records and collect information for Mental Health Information Systems
- Provide mental health education to patients, families and the community

at large.

4.2.4.3 Community Level

At this level, the responsible people for mental health programmes are the individuals, families, community volunteers, community own resource persons and community leader in collaboration with PHC nurses and the medical rehabilitation workers.

Important responsibilities at this level include:

Primary prevention

- Promote the value of a healthy life style, stable interpersonal relationships, a conducive family environment, balanced diet, regular exercise, rest and recreation, social and cultural integration abstinence from addictive substances, the importance of pre and post natal care, and immunization
- Mobilize resources and advocate for changes in community attitudes with regard to the causes and treatment of mental disorders
Support the establishment and maintenance of volunteer programmes, and family support group through the provision of incentives and other resources

Develop support systems for the promotion of mental health and the prevention of mental illness
- Develop advocacy and pressure groups to support patients and their families, such as The Namibian Association for Mental Health, Schizophrenia Action Groups, Alcohol Anonymous Support Group, **etc**

Secondary prevention

- Early detection and referral of mentally disordered individuals, including those suffering from psychosis, depression and epilepsy
- Develop facilities for rehabilitation, including halfway houses, day centres and sheltered employment
- Treatment, **support** and follow-up of patients

Tertiary prevention

- Mobilize the community for early reintegration of mentally disordered individuals into the community
- Establish community-based rehabilitation programmes and facilities
- Encourage regular follow-up of discharged patients, **provide treatment motivators and ensure the early detection** of those who are non-compliant.

4.3.   The National Inter-sectoral Mental Health Action Group

Mental health activities involve various ministries and non-governmental organizations. It is therefore necessary to establish a Mental Health Action Group in order to streamline and coordinate the activities across various stakeholders. Members of such a collaborative effort should include senior government officials to enhance decision-making and implementation.

4.4.1 Functions of the Action Group

- Act as forum for an inter-sectoral approach to the promotion of mental health, and prevention, treatment, and rehabilitation of mental illnesses
- Develop support systems to promote mental health and the advancement of psychosocial development of all citizens
- Render advisory services to the MoHSS
- Co-operate with the MoHSS, national, international, and non-government organizations to achieve the national goal of Health for All Namibians

4.4.2 Membership:

- **Ministry of Health, Social Services and Rehabilitation** (one chairperson and a facilitator)
- Office of the Prime Minister
- **Ministry of Education**
- Ministry of Gender **Equality and Child Welfare**
- Ministry of Information and Broadcasting
- Ministry of Justice
- **Ministry of Labour and Social Welfare**
- Ministry of Lands, Resettlement
- Ministry of Regional, Local Government and Housing and Rural Development
- **Ministry of Safety and Security (Namibian Police and Prison)**
- University of Namibia
- Representatives of non-governmental organizations, faith-based organizations, private sector and communities

4.5 Responsibilities of the Various Sectors

4.5.1 Ministry of Health and Social Services

- Provide and manage the national mental health services
- Monitor and evaluate mental health issues and problems in the country
- Develop program-specific mental health policies and guidelines
- Develo**p and update mental health legislation and regulations**
- Assure quality and equitable distribution of mental health services
- Assist with the curriculum development for the training of mental health workers
- Develop human resources for the provision of mental health services
- Provide a budget for mental health services
- Develop resource manuals, to be used by professionals and the community at large
- Develop and distribute IEC material
- Coordinate the activities of the various ministries and non-governmental organizations
- Coordinate bilateral, and international efforts in the mental health programme
- Join regional associations for the promotion of mental health activities
- Provide disability grants for mentally disabled people

4.5.2 Ministry of Education

- Enable teachers to detect learning disabilities and make the appropriate referrals to special educational programmes, if and when available
- Detection of child abuse and behavioural problems in childhood
- Provide health and mental health education, including but not limited to alcohol and substance abuse
- Early detection and screening of childhood mental disorders
- Provide appropriate placement of mentally gifted children
- Promote healthy life styles and constructive use of leisure time through the enhance of sport and physical exercise and the active promotion of cultural activities.
- Incorporate a mental health component in the curriculum for teachers
- Employ educational psychologists and school counsellors/regional school counsellors to perform psychological testing, in order to
  diagnose mental health problems, offer support and, when
  necessary, refer to adequate treatment.
- Support school counsellors/regional school counsellors and life skills teachers to provide counselling, mental health promotion and prevention of disorders.
- Promote healthy life styles in educational institutions
- Establish or strengthen student counselling services at colleges and other educational institutions
- Screen for early symptoms of mental health problems
- Provide scholarships and other financial assistance for the training of mental health professionals.
- Include and develop mental health components in the training of a variety of professions including nurses, teachers and occupational therapists.
- Establish specialized health programmes

4.5.3. Ministry of Gender Equality and Child Affairs

- Liase with the MOHSS to develop ways of promoting mother-infant bonding and promoting the mental health of women and children.

4.5.4. Ministry of Information and Broadcasting

- Dissemination of information on mental health.
- Promoting the image of mental health in both print and electronic media.

4.5.5. Ministry of Justice

- Protect the rights of mentally ill individuals, including offenders
- Participate in drafting and reviewing the Mental Health legislation
- Implement the legal procedures on the admission and discharge of mentally ill patients
- Develop guidelines for the referral of offenders for psychiatric assessment in collaboration with the MOHSS
- Provide mental health training for magistrates and judges, including the provisions

4.5.6. Ministry of Labour and Social Welfare

- Encourage the public and private sectors to establish sheltered employment workshops for persons with mental disorders
- Promote the employment of people with disabilities through the Employment Equity Act
- Protect people with mental disorders in the workplace by safeguarding their legal rights, in keeping with the Labour Act
- Provide vocational counselling services

4.5.7. Ministry of Lands and Resettlement

- Mobilize people with mental disorders to organize themselves into groups that will strive for their full reintegration into society.
- In collaboration with MoHSS, Ministry of Lands, Resettlement and Rehabilitation will raise awareness on the right of people with mental disorders and protect them against discrimination.

4.5.8. Ministry of Regional, Local Government and Housing

- Budget for community activities related to mental health.
- Support the activities of mental health volunteers
- Provide community residential care (such as halfway houses, group homes)
- Liaise with the MOHSS in the development of residential care
- Advocate among the governors for support for mental health in the community and the needs of people with mental disorders

4.5.9. Ministry of Safety and Security (Namibian Police and Prison)

- Manage prisoners with mental health problems and refer them to mental health services when indicated
- Promote mental health among prisoners and encourage healthy   life styles
- Work in close cooperation with the Ministry of Health and Social Services.
- Observe the relevant stipulations in the Mental Health Act.
- Provide mental health training for prison officers, and select prison officers for training by the MoHSS
- Provide mental health training for law enforcement officers in the police force, in collaboration with the MoHSS. Mental health should be included in the basic training of police officers and training of those police officers who are already qualified
- Implement sections of the Mental Health Act which deal with the responsibility of the police officers, concerning mentally ill individuals
- Ensure that the rights of people with mental disorders should are protected and promoted by all law enforcement officers.

4.5.10. University of Namibia

- Training of all health workers in mental health at both basic and advanced levels.
- Establish mental health research programmes.

4.5.11. Non Governmental Organizations and the Community

- Develop support systems to promote mental health and prevent mental illness
- Develop facilities for treatment and rehabilitation
- Establish and support advocacy groups, such as, The Namibian Association for Mental Health, Schizophrenia Support Group, Alcoholics Anonymous, etc.
- Collaborate with the MOHSS and other relevant players in the development of mental health care services.

CHAPTER 5: CONSIDERATIONS FOR IMPLEMENTATION

5.1 Resource Implications

All stakeholders should mobilize the necessary financial and human resources for the implementation of their responsibilities related to this mental health policy.

5.2 Key implementation phases

The main features in the implementation of this policy are the training of mental health workers, decentralization and integration of the mental health services with existing health services and the development of a network of organisations, services and referral systems. A strategic plan and guidelines will be formulated in accordance with this policy to enhance implementation.

5.3 Monitoring and evaluation

5.3.1   Monitoring

The progressive monitoring of the programme will be carried out in accordance with the five-year strategic plan and annual action plans. Records related to the indicators specified in the mental health programme will be kept at regional, district and clinic levels. Supervision will be carried out regularly at national, regional and district levels.

Mental health information systems need to be developed, and integrated into the overall health information system, to enable the monitoring of mental health services.

5.3.2 Evaluation

Periodic evaluation and review of the programme will be undertaken to ensure that activities are carried out as planned. Information on services, morbidity and mortality will be collected and analysed.

5.4 Conclusions

The policy emphasizes that mental health is a component of the overall health care **and social welfare** system. It enumerates practical steps to move away from the current centralized, curative and hospital-based mental health services to one that is comprehensive and integrated into the general health and **social welfare** system based on a Primary Health Care and **developmental social welfare** approach and strongly supported by intersectoral collaboration and community participation. The key to change depends on the availability of the right quality and quantity of trained human resources and a proportionate allocation of financial resources.

GLOSSARY

1. **Bipolar Disorder:** A disorder of mood characterised by both marked mood elevation (or mania) and marked mood depression. Bipolar disorder can have psychotic features.

2. **Care:** The reduction of discomfort and disability rather than cure. The symptoms and their disturbing qualities are mitigated and the individual returns to acceptable levels of social functioning. Disability is reduced or eliminated.

3. **Cure:** Implies complete termination of mental disorders and the return of individuals to normal health. This end of the spectrum typifies the traditional medical model, though it is rarely achieved with mental illness, except for those conditions in which there is mainly an organic aetiology.

4. **DALY:** Disability Adjusted Life Years (DALY) is the sum of years of life lost due to premature mortality and years lost due to disability.

5. **Delusion:** A false belief held despite evidence to the contrary.

6. **Electro convulsive therapy:** Employing the application of electric shocks to the brain, which induce a convulsion for the treatment of some mental illnesses.

7. **Hallucinations:** sensory experiences not shared by others, such as hearing voices.

8. **Health:** The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not simply the absence of disease or infirmity".

9. **Mental health:** Mental health is a state of complete well-being that enables the fulfilment of one's full potential in occupational, social and relational functioning.

10. **Neurosis**: Relatively mild illness involving symptoms of stress and anxiety. There is no loss of contact with reality.

11. **Prevention:**

     Primary Prevention: Refers to methods designed to avoid the occurrence of disease or impairment, such as proper nutrition, pre-natal and post-natal care, immunization, and so forth.

     Secondary Prevention: Refers to early diagnosis and treatment of conditions, in order to shorten illness episode and to stop or shorten sequealae, such as effective and early treatment of mental disorder. E.g. the effective treatment of epilepsy reduces injuries and accidents.

     Tertiary Prevention: Refers to measures taken, in order to limit disability as

a result of disease processes, which may not be fully curable, such as the treatment of schizophrenia, to maintain interpersonal skills.

12. **Mental Health Promotion:** This is a broad concept aimed at enhancing mental health, through integrated actions at different levels of, service that influences health. The activities in question involve but are not limited to prevention. Mental health promotion is broader and deeper, and as such it includes biological, environmental, and sociological issues. It provides a possible frame of reference from which agreed upon priorities can be established and activities across the entire spectrum of efforts in mental health can be monitored.

13. **Psychosis:** A severe mental disorder, with major features being hallucinations and delusions.

14. **Rehabilitation**: Activities that aim at maximizing opportunities for the individual recovery process and attempt to minimize the negative impact of chronic conditions. Frequently, this requires manipulation of the environment at individual, family and community level. The inborn natural healing processes in the individual are fostered, and environmental changes are instituted, which minimize the effects of any impairment brought about by illness.

15. **Schizophrenia**: A mental disorder characterized by psychosis, noticeable decline in the level of functioning in everyday life, and disintegration of personality expressed as discord in feelings, thoughts, and behaviour. This condition is frequently accompanied by delusions, hallucinations and a retreat from social life.

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