



Hampshire Partnership 
NHS Foundation Trust



Kintampo Rural Health Training School

Ministry of Health

Curriculum for
Community Mental Health Officer

The
KINTAMPO
project

Ghana-Hampshire (UK)
Mental Health Link

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Version Control

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Preface

Welcome to an initiative to significantly improve the care of people with mental disorder in Ghana. The purpose of this document is to describe the education programme and the initial development of two new types of mental health practitioner within the Ghanaian health system. It has been developed through the commitment of the Government of Ghana (GoG) via the Ministry of Health and Ghana Health Service and is a partnership between Ghana and the UK through collaboration with Hampshire Partnership NHS Foundation Trust and Kintampo Rural Health Training School. This document presents one of two curricula to establish new middle level health professionals in mental health who will contribute to the transformation of mental health services in the country. A programme of research and ongoing development will ensure that these roles will improve the quality of life for the people of Ghana through delivering the best possible care where it is most needed.

There are two curricula, each with its own academic qualification, which are very closely linked and complement each other. The curricula are:

- 1. Diploma in Community Mental Health, leading to Community Mental Health Officer (CMHO) – described in this document.**
2. Degree in Clinical Psychiatry, leading to Medical Assistant Psychiatry (MAP).

Signed

Minister of Health

Date

Readership

This document is written for:

- Policy makers in health and education
- All stakeholders involved in the development of the MAP and CMHO curricula.
- Mental Health Service Providers
- Mental Health Service Users
- Civil Society
- Non - Governmental Organisations (NGOs)
- Educators of MAP and CMHO
- Any person wishing to become a MAP or CMHO
- Anyone likely to work alongside MAP or CMHO
- Any organization or entity wishing to employ a MAP or CMHO

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Abbreviations

| | |
|-----------------|---|
| ANPH | - Ankaful Psychiatric Hospital |
| APH | - Accra Psychiatric Hospital |
| CBSV | - Community Based Surveillance Volunteer |
| CHCM | - Community Health Committee Member |
| CHN | - Community Health Nurse |
| CHO | - Community Health Officer |
| CHPS | - Community-based Health Planning and Services |
| MAP | - Medical Assistant Psychiatry |
| COHO | - Community Oral Health Officer |
| CPN | - Community Psychiatric Nurse |
| FT | - Field Technician |
| GES | - Ghana Education Service |
| GHS | - Ghana Health Service |
| GoG | - Government of Ghana |
| HIV/AIDS | - Human- Immune- Deficiency Virus/ Acquired Immune Deficiency Virus |
| KRHTS | - Kintampo Rural Health Training School |
| MA | - Medical Assistant |
| MAP | - Medical Assistant Psychiatry |
| MDGs | - Millennium Development Goals |
| MOH | - Ministry of Health |
| NGO | - Non Governmental Organisation |
| PHC | - Primary Health Care |
| PH | - Pantang Hospital |
| SSA | - Sub-Saharan Africa |
| SDHT | - Sub-District Health Team |
| TBA | - Traditional Birth Attendant |
| TO | - Technical Officer |
| WHO | - World Health Organisation |
| WTE | - Whole Time Equivalent |

The Curriculum

Diploma in Community Mental Health

The 1 year Diploma in Community Mental Health will enable practising Community Health Officers to become specialists in mental health, and successful completion of the programme will render them eligible to practise as a specialist Community Mental Health Officer.

Community Health Officers are a category of health professional currently functioning in CHPS (Community-Based Health Planning and Services) compounds. They already have a broad clinical background which will enable them to function as CMHO after further training in psychiatry.

The rationale for the qualification and the CMHO can be seen in Appendix A.

1.0 Aims and Objectives

- 1.1** The programme provides the education and training to develop as a Community Mental Health Officer. A description of the function, roles and practice of the Community Mental Health Officer can be seen in Appendix B.
- 1.2** The level of training is such as would be comparable with international standards. This is ensured by the involvement of visiting clinical and academic staff and external examiners for final exams.
- 1.3** This is a programme for mature candidates. It is predominantly practice based.

2.0 Duration of the Programme

- 2.1** The duration of the CMHO programme is one academic year (12 months), comprising two semesters and a recess period. The programme follows the semester course unit system (SCUS) of KRHTS

3.0 Entry Requirements

Entrants shall be:

Step 1

A Field Technician possessing the Certificate in Community Health (or it's equivalent from a recognised health training institution) who is a practising Community Health Officer

Or

A Community Health Nurse possessing the Certificate in Community Health Nursing (or it's equivalent from a recognised health training institution) who is a practising Community Health Officer

And

Step 2

Have served two years minimum in deprived areas or three years minimum in non-deprived areas.

Note: The number of students accepted into the School shall reflect the expressed national manpower needs as defined by the Ministry of Health.

4.0 Assessment Requirements

4.1 Students' performance in each course shall be calculated at the end of the semester as an 'End of Semester Assessment'. It shall consist of the results of both **(a)** field / practice based Continuous Assessment and **(b)** a school based End of Semester Examination.

The weighting of the two elements of the End of Semester Assessment shall be as follows:

a) Field based / practice - Continuous Assessment = 40%

This will include assessment of:

practice based performance in field sites

and

satisfactory maintenance of a learning portfolio

b) End of Semester Examination = 60%.

The End of Semester Examination combines the results of assignments and quizzes, mid-semester assessment and end-of-semester examinations taken in school. The weighting of the assignments and quizzes, mid-semester assessment and end-of-semester examinations taken in school is as follows:

- assignments/quizzes 15%
- mid-semester assessment 15%
- end-of-semester examinations 70%

4.2 The following grading system applies to the internal examinations:

| Letter Grade | Score Range (%) | Grade Point | Description |
|--------------|-----------------|-------------|--------------------|
| A | 80-100 | 4.00 | Distinction |
| A- | 75-79.99 | 3.75 | Very Good |
| B+ | 70-74.99 | 3.00 | Credit |
| B | 65-69.99 | 2.75 | Above Average |
| C | 60-64.99 | 2.50 | Average |
| D | 50-59.99 | 1.5 to 2.00 | Pass |
| F | <50 | 1.00 | Fail |
| I | 0.00 | 0.00 | Absent With Reason |
| X | 0.00 | 0.00 | Absent |
| Z | 0.00 | 0.00 | Disqualified |

4.3 Any student who fails in any course (subject) at the end of the academic year is required to redeem the course which means repeating all the assessments again for that course (assignments, class tests, quizzes, mid and end-of-semester examinations).

4.4 There are only three chances to redeem a course.

4.5 If the GPA/CGPA falls below 1.5 at the end of any academic year the student will not continue with the programme.

4.6 Transcripts reflect all grades and marks a student obtains for all courses (subjects) taken and these are used in the computation of a student's GPA/CGPA.

4.7 Full examination details and regulations can be seen at Appendix C.

5.0 Requirements for Diploma in Community Mental Health

- 5.1** On completing the courses students must sit a final professional examination which if successful leads to the award of Diploma in Community Mental Health.
- 5.2** To be eligible to sit the final professional examination a student must:
 - a)** have a total of at least 30 credit hours of course work
 - b)** pass in all courses taken earning a cumulative GPA of 1.5 or better
 - c)** a student should have a GPA of 1.5 or better in each course
- 5.3** Certification assessments for the final professional examination are by External Examiners appointed by MoH/GHS. Only students who have passed all requirements at the end of the course of study are assessed.
- 5.4** The assessment is in two parts – mock and final. The mock is organized by KRHTS to prepare students for the final assessment.
- 5.5** An average score for the final professional examination which is below 50% is a fail of the entire assessment and there are two more chances only to go through the whole assessment again.
- 5.6** Students scoring below 50% in any aspect of the final professional examination have the opportunity to go through that aspect of the assessment within six months upon declaration of results. Three chances are allowed here.

6.0 Important Additional Information

- 6.1** The educational principles underpinning the design of the CMHO Curriculum and its structure can be seen at Appendix D
- 6.2** The arrangements for clinical placements and work in school can be seen at Appendix E
- 6.3** The management of the programme and recruitment can be seen at Appendix F
- 6.4** Resources available can be seen at Appendix G
- 6.5** Administration and education structures can be seen at Appendix H
- 6.6** The programme quality assurance procedures can be seen at Appendix I
- 6.7** The evaluation methods for the programme can be seen at Appendix J
- 6.8** The process by which the curriculum was produced can be seen at Appendix K

7.0 Programme Structure

- 7.1** The programme has been developed along the Semester-Course-Unit System (SCUS) adopted by Ministry of Health Training Institutions. This is in conformity with Universities in Ghana and integrates the programme into the education system.
- 7.2** In this programme, a classroom credit is the equivalent of 16 hours of instruction per semester. A two (2) classroom credit course would have two (2) contact hours a week for 16 weeks, giving a total of 32 hours. One (1) credit of field course work (practical course work) would be 6 contact hours a week for 16 weeks. Two (2) credits of field course work (practical course work) would be 12 contact hours per week for 16 weeks giving a total of 192 hours.
- 7.3** The Programme is one academic year. It comprises 2 semesters of school based work and clinical placements.
- **First Semester:** 16 weeks (2 week registration/ orientation, 11 weeks instruction, 1 week mid-semester exam and 2 weeks end of semester exams)
 - **Second Semester:** 16 weeks (13 weeks instruction, 1 week mid-semester exam and 2 weeks end of semester exams)

Content of the courses

- 7.4** The courses cover the theoretical knowledge, clinical skills and experiences that the students will need to acquire and demonstrate during their training and practice. The content outlined below provides the students and the supervisors (tutors and preceptors) with the basis for developing a plan for learning, and formative and summative assessment. The syllabus will be reviewed at agreed intervals to meet the development of the programme.
- 7.5** The students will keep records of their learning as well as the outcomes of assessments.
- 7.6** All courses will build on the previous knowledge, skills and clinical experiences and academic achievements of the students. The later courses will be the application or continuation of previous courses. Practical work and assessment may occur within clinical placements (field work visits / attachments). The field work component of the semesters will account for 70% of the syllabus. The field work component will take place in clinical settings and communities. The descriptions give only broad headlines of topics to be covered in the programme; detailed content of the topics will be developed by the programme heads and tutors.

Knowledge, Skills and Attitudes

7.7 Given the starting point of the student, the overall aims and the educational rationale for the programme, the following will be required of students in relation to psychiatry:

- To develop the knowledge, skills and attitudes necessary for the recognition and monitoring of psychiatric disorders in the community.
- To develop a basic understanding of psychology relevant for mental health practice.
- To understand the history of psychiatry in Ghana.
- To attain practical skills in case identification, supporting the care of patients in the community and conducting mental health education.
- To understand the concepts and principles of psychiatric (mental health) practice in the community.
- To develop a basic understanding of and some basic skills in relevant psycho-social treatments used in psychiatric practice.
- To understand the role of others in the management of psychiatric disorders, to include other professionals, services and agencies.
- To develop the knowledge and skills required for use in the identification of drug and alcohol problems, their management and to provide education on drug and alcohol use and abuse.
- To develop an understanding of how psychiatric problems present in medical (physical) conditions and how to recognise and monitor them.
- To understand the use and adverse effects of medications that are commonly used in treating psychiatric disorders.
- To acquire the skills and experience needed for good team working, team building and for providing psychiatric care in the community through multi-agency working.
- To understand and use ethical principles for good psychiatric practice.
- To understand and demonstrate excellent professional attitudes and behaviour in relation to psychiatric practice.
- To understand the ethical and legal aspects of use and abuse of medications.
- To understand and develop relevant skills and knowledge concerning the overlap between crime, criminal justice systems and psychiatric disorders.
- To understand how research, audit and evidence influence the practice of psychiatry.
- To develop the ability to assess and undertake the immediate management of psychiatric emergencies and acute conditions.
- To be aware of how psychological/psychiatric problems present in children, the mentally retarded and elderly persons, and to understand the basics of care for these groups of people.

8.0 Structure of the Semesters

Semester I

| Code | Course | C | F | TC |
|----------|---|---|---|----|
| CMHO1101 | General psychiatry and psychology I | 2 | 2 | 4 |
| CMHO1102 | Community Mental Health Practice I | 1 | 1 | 2 |
| CMHO1103 | Drugs, medications, physical health and psychiatry | 2 | 1 | 3 |
| CMHO1104 | Team building and communication | 1 | 1 | 2 |
| CMHO1105 | Ethics & professionalism | 1 | 1 | 2 |
| CMHO1106 | Research, audit, project work & evidence-based practice | 1 | 1 | 2 |
| | TOTAL | 8 | 7 | 15 |

Semester II

| Code | Course | C | F | TC |
|----------|---|---|----|----|
| CMHO1201 | General psychiatry II | 2 | 2 | 4 |
| CMHO1202 | Community mental health practice II | 1 | 2 | 3 |
| CMHO1203 | Basic clinical psychopharmacology | 1 | 1 | 2 |
| CMHO1204 | Psychosocial aspects of treatment | 1 | 2 | 3 |
| CMHO1205 | Child psychiatry Learning disability Older people's mental health | 1 | 2 | 3 |
| CMHO1206 | Project work | 1 | 2 | 3 |
| | TOTAL | 7 | 11 | 18 |

C = Classroom credit, F = Field credit, TC = Total credit

Course Descriptions

Semester 1

| CMHO1101 | General Psychiatry and Psychology I (4 Credits) |
|---------------------|--|
| Course Aims | <p>To enable the student to acquire knowledge, skills and attitudes necessary for the recognition and monitoring of psychiatric disorders in the community</p> <p>To develop a basic understanding of psychology relevant for mental health practice</p> <p>For students to understand the history of psychiatry in Ghana</p> |
| Learning Intentions | <p>By the end of the course the student should be able to demonstrate understanding of (and where relevant, skills in):</p> <ul style="list-style-type: none"> • Concepts of normality and abnormality in relation to mental disorder • The psychological and social components of good mental health • Basic psychology and behaviour relevant to mental health practice • Human psychological and personality development • Personality and personality disorder • Traditional beliefs and practices in relation to mental health • Causes of mental disorders • The different types of mental disorder relevant for community mental health practice • The signs and symptoms of psychiatric disorders • Taking and writing up a psychiatric history and, eliciting symptoms and signs of common psychiatric disorders • The history of psychiatry in Ghana, the psychiatric institutions and models of care |
| UNIT 1 | <p>Introduction to psychiatry and mental health</p> <p>1.1 Concepts of normality and abnormality</p> <p>1.2 Components of good mental health</p> |
| UNIT 2 | <p>Psychology and psychiatry</p> <p>2.1 Past and contemporary psychological and behavioural concepts for clinical practice</p> <p>2.2 Personality and basics of personality disorders</p> |
| UNIT 3 | <p>Belief systems, psychiatry and the causes of mental disorders</p> <p>3.1 Traditional beliefs and practices</p> <p>3.2 Myths and psychiatry</p> <p>3.3 General features of abnormal mental states</p> <p>3.4 Causes of psychiatric disorders – biological, psychological and socio-cultural causes – the basics</p> |

table continues...

| | |
|--------|--|
| UNIT 4 | <p>The psychiatric disorders:</p> <ul style="list-style-type: none"> 4.1 Overview of classifications of psychiatric disorders 4.2 Psychotic disorders 4.3 Mood disorders 4.4 Anxiety-related disorders 4.5 Drug & Alcohol-related disorders 4.6 Psychiatric disorders due to medical conditions 4.7 Organic brain disorders, dementia 4.8 Developmental disorders 4.9 Epilepsy |
| UNIT 5 | <p>Signs and symptoms of psychiatric disorders:</p> <ul style="list-style-type: none"> 5.1 Abnormal behaviour 5.2 Disorders of speech and thinking 5.3 Disorders of perception 5.4 Disorders of emotions/mood 5.5 Disorders of movement 5.6 Cognitive state and dysfunction 5.7 Insight |
| UNIT 6 | <p>Assessing the patient</p> <ul style="list-style-type: none"> 6.1 Basic history taking in psychiatric practice 6.2 Basic interviewing skills for psychiatric practice 6.3 Basic mental state examination 6.4 Investigation – social, biological, psychological 6.5 Basics of clinical formulation and differential diagnosis |
| UNIT 7 | <p>Exploring the history of psychiatry with particular reference to psychiatry in Ghana</p> |

| CMHO1102 Community Mental Health I (2 Credits) | |
|--|--|
| Course Aim | To enable the student to acquire an understanding of the concepts and principles of community mental health practice and the role of various agencies in promoting mental health |
| Learning Intentions | By the end of the course the student should be able: <ul style="list-style-type: none"> • To understand the concepts and principles of psychiatric (mental health) practice in the community • To understand the role of others in the management of psychiatric disorders, to include other professionals, services and agencies. |
| UNIT 1 | Community psychiatric practice: concepts and importance |
| UNIT 2 | The roles of members of the community and practitioners <ul style="list-style-type: none"> 2.1 Community mental health practitioners at primary and secondary care levels 2.2 Social services 2.3 Religious groups / organisations 2.4 Traditional healers 2.5 The family and its role in mental health and access to care 2.6 Community leaders and their role in promoting mental health 2.7 The specific role of the CMHO |
| UNIT 3 | Identifying vulnerable groups in the community |
| UNIT 4 | Introduction to rehabilitation |

| CMHO 1103 Drugs, Medications, Physical Health and Psychiatry (3 Credits) | |
|--|--|
| Course Aims | <p>To acquire the knowledge and skills for use in the identification of drug and alcohol problems, their management and to provide education on drug and alcohol use and abuse.</p> <p>To acquire an understanding of how psychiatric problems present in medical (physical) conditions and how to recognise and monitor them.</p> <p>To enable the student to begin to understand the use and adverse effects of medications that are commonly used in treating psychiatric disorders.</p> |
| Learning intentions | <p>By the end of the course the student should be able to:</p> <p>Drugs and alcohol</p> <ul style="list-style-type: none"> ● Describe patterns of normal use of alcohol ● Describe alcohol problems and their causes ● Describe drug problems and their causes ● Identify a problem drinker and provide support and education ● Identify drug abusers and provide relevant advice ● Assess and assist in the management of various degrees of alcohol misuse including acute and long-term complications <p>Physical illnesses and psychiatry</p> <ul style="list-style-type: none"> ● Demonstrate an understanding of the co-occurrence of psychiatric disorder and physical illness in various settings including community, outpatients, hospitals and institutions. ● Recognise the presence of psychiatric problems in the patient presenting with physical conditions ● Recognise general medical conditions in patients with psychiatric disorders. <p>Medication and side effects</p> <ul style="list-style-type: none"> ● Begin to have a basic understanding of medications used in psychiatry and their side effects |
| UNIT 1 | <p>Definitions</p> <p>1.1 What is substance misuse / harmful use / dependence / tolerance</p> |
| UNIT 2 | Causes of drug and alcohol abuse and the extent and nature of the problem |
| UNIT 3 | Assessment of alcohol misuse and drug misuse |
| UNIT 4 | <p>Complications of alcohol misuse</p> <p>4.1 Socio-cultural and legal</p> <p>4.1 Physical complications</p> <p>4.3 Psychiatric complications</p> <p>4.4 Intoxication/overdose</p> <p>4.5 Withdrawal effects</p> |

table continues...

| | |
|--------|--|
| UNIT 5 | <p>Education and Principles of Management</p> <p>5.1 General measures</p> <ul style="list-style-type: none"> a) Harm reductionCounselling b) Self-help groups c) Assertiveness skills d) Vocational rehabilitation e) Crisis intervention f) Inpatient care <p>5.2 Monitoring of treatment methods</p> <ul style="list-style-type: none"> a) Detoxification for alcohol b) Management of alcohol withdrawal effects c) Use of anti-craving medications <p>5.3 The law and drug control policies and prevention of abuse</p> |
| UNIT 6 | <p>Understanding the association between psychiatric and physical disorders</p> <p>6.1 Psychological factors as causes of physical illness</p> <p>6.2 Psychiatric disorders presenting with physical symptoms</p> <p>6.3 Psychiatric consequences of physical illness</p> <p>6.4 Psychiatric and physical disorders occurring together by chance</p> <p>6.5 Psychiatric problems with physical complications:</p> <ul style="list-style-type: none"> a) attempted suicide and deliberate self-harm b) alcohol and other substance abuse c) eating disorders such as anorexia and bulimia |
| UNIT 7 | <p>Identification of psychiatric disorders associated with physical illness</p> <p>7.1 Consultation for patients in medical settings</p> <p>7.2 Medically unexplained symptoms</p> <p>7.3 Education of non-mental health care staff</p> |
| UNIT 8 | <p>Introduction to psychiatric side effects and consequences of treatments for physical disorders</p> |

| CMHO1104 TEAM BUILDING AND COMMUNICATION (2 CREDITS) | |
|---|--|
| Course Aim | To enable the student to acquire the skills and experience needed for good team working, team building and for providing psychiatric care in the community through multi-agency working |
| Learning Intentions | <p>By the end of the course the student should be able to:</p> <ul style="list-style-type: none"> • Describe what makes a good team, and be able to clarify a team's purpose and goals • Help members of their team work well together, to strengthen the team's collective skills, to enhance commitment and confidence, so that its members jointly perform at high level • Be able to create opportunities for team members to develop their skills and competence • Understand concepts and principles of good communication both at an individual and group level • Understand how communication processes work, and what makes them successful or not • Understand some specific relevant approaches that aid effective communication • Understand where barriers and blockages to communication can arise, and how to take steps to overcome them • Understand how communication processes can be manipulated and corrupted and why this occurs |
| UNIT 1 | <p>Teams</p> <p>1.1 What is a team?</p> <p>1.2 What are the characteristics of teams?</p> <p>1.3 What are the factors that contribute to a team's effectiveness?</p> <ul style="list-style-type: none"> a) Interpersonal understanding b) Influence c) Patient/service orientation d) Adaptability e) Achievement orientation f) Organisational commitment <p>1.4 How can team performance be assessed?</p> <ul style="list-style-type: none"> a) Outcome measures b) Quality of the processes contributing to the results or outcome <p>1.5 How can team performance reviews be conducted?</p> <p>1.6 What needs to be done to obtain good team work?</p> |
| UNIT 2 | <p>Communication</p> <p>2.1 Listening skills</p> <p>2.2 Verbal and non-verbal communication</p> <p>2.3 Interviewing skills – individuals and groups</p> <p>2.4 Effective communication</p> <p>2.5 Structuring communication and communication systems</p> <p>2.6 Communication policies and priorities</p> |

| CMHO1105 Ethics And Professionalism In Relation To Psychiatric Practice (2 Credits) | |
|--|--|
| Course Aims | To understand and use ethical principles for good psychiatric practice. To understand and demonstrate excellent professional attitudes and behaviour in relation to psychiatric practice |
| Learning Intentions | By the end of the course the student should be able to: <ul style="list-style-type: none"> • Understand the concepts and principles of ethics • Describe ethical issues for mental health practitioners • Apply an understanding of ethics when caring for patients, their families and communities • To understand and demonstrate excellent professional attitudes and behaviour in relation to CMHO practice • Apply ethical and professional principles in psychiatric practice for CMHOs |
| UNIT 1 | Ethical issues in mental health promotion <ol style="list-style-type: none"> 1.1 Concept of ethics 1.2 Beneficence 1.3 Capacity 1.4 Respect to life 1.5 Confidentiality and privacy 1.6 Professionalism |
| UNIT 2 | Ethical Aspects of Psychiatry <ol style="list-style-type: none"> 2.1 Ethics, norms and codes 2.2 Ethical values and attitudes 2.3 Duties towards the profession 2.4 Duties towards the public |
| UNIT 3 | Professionalism and Psychiatry <ol style="list-style-type: none"> 3.1 Professional attributes and behaviour 3.2 Clinician-patient relationship/boundaries 3.3 Principles and practice of confidentiality 3.4 Lifelong learning and continuous professional development (CPD) |
| UNIT 4 | Confidentiality and Psychiatric Practice <ol style="list-style-type: none"> 4.1 Confidentiality and its boundaries 4.2 Breaching confidentiality <ol style="list-style-type: none"> a) Capacity b) Paternalistic justification 4.3 Community psychiatry and challenges to the traditional medical and ethical perspective on patient confidentiality 4.4 Information sharing within the multidisciplinary team and other agencies 4.5 Sharing information with carers <ol style="list-style-type: none"> a) When in the patient's best interest b) When acting to reduce risk to the well-being of the family 4.6 Confidentiality when providing care in public places 4.7 Ethical issues in risk assessment and management |

| CMHO1106 Research, Audit, Project Work and Evidence-Based Practice (2 Credits) | |
|---|--|
| Course Aim | To understand how research, audit and evidence influence the practice of psychiatry |
| Learning Intentions | By the end of the course the student should be able to: <ul style="list-style-type: none"> • Understand the basics of research and how to gather data for research in mental health • Understand basic research information and analysis used in the field of mental health and allied areas(e.g. sociology, psychology, anthropology) • Describe the sources of mental health information available for practitioners • Understand the processes and use of audit and field survey in mental health • Access, appraise and apply evidence based practice |
| UNIT 1 | Understanding the basics of research in mental health To include: <ul style="list-style-type: none"> a) Types of data: prospective, retrospective, qualitative, quantitative, case study research b) Research methods: including observation studies, interviewing and surveys. |
| UNIT 2 | Sources of mental health information and conducting literature search |
| UNIT 3 | Introduction to audit and field survey in mental health To include: <ul style="list-style-type: none"> a) What are audit, research and action research? b) What are their aims? c) How do they differ? |
| UNIT 4 | Use of information in mental health gathered through research, audit and field surveys <ul style="list-style-type: none"> 4.1 Data analysis 4.2 Grounded theory 4.3 Impact on future practice 4.4 Follow up research |

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| UNIT 5 | <p>An introduction to project work for mental health practice</p> <p>To include:</p> <p>5.1 Overview of educational project research process:</p> <ul style="list-style-type: none">a) Identifying areas for research/project work (including health education and promotion)b) Clarifying problems/issues to be researchedc) Stating research aimsd) Defining research questionse) Identifying appropriate research methodsf) Collecting datag) Analysing datah) Discussing data/conclusions and recommendationsi) Preparing a report of the research findings <p>5.2 Research ethics:</p> <ul style="list-style-type: none">a) Confidentiality and anonymityb) Informing relevant people about the researchc) Negotiating 'entry' (and 'exit')d) Obtaining consente) Power relationf) Feedback to research subject(s)g) Conflicts of interest |
|--------|---|

Second Semester

| CMHO1201 General Psychiatry II (4 Credits) | |
|--|---|
| Course Aims | To enable the student to develop the ability to assess and undertake the immediate management of psychiatric emergencies and acute conditions For students to understand and develop relevant skills and knowledge concerning the law and also the overlaps between crime, criminal justice systems and psychiatric disorders |
| Learning intentions | By the end of the course the student should be able to: <ul style="list-style-type: none"> ● Demonstrate knowledge of various psychiatric emergencies and acute conditions ● Identify and assess psychiatric emergencies and acute conditions ● Undertake the safe initial management of psychiatric emergencies and acute conditions ● Describe the relevant aspects of civil and criminal law that relate to psychiatry ● Understand the associations between psychiatric disorder and crime ● Understand the workings of the court, prisons and the police in relation to psychiatric disorders ● Perform initial assessment of a mentally disordered offender and provide advice and support to the offender as well as the law enforcement agencies |
| UNIT 1 | The psychiatric emergencies and acute conditions – overview and assessment in practice. <ol style="list-style-type: none"> 1.1 Self-harm/Attempted Suicide and Suicide 1.2 Violence and aggressive behaviour 1.3 Severe mania 1.4 Acute psychosis 1.5 Catatonic stupor/excitement 1.6 Acute confusion and delirium 1.7 Acute severe adverse effects of medications (e.g. dystonia, parkinsonism) 1.8 Status Epilepticus 1.9 Others e.g. panic attacks, acute intoxication and withdrawal states |
| UNIT 2 | Approaches used in the management of emergencies <ol style="list-style-type: none"> 2.1 De-escalation 2.2 Control and restraint 2.3 De-briefing 2.4 Use of seclusion 2.5 Monitoring of rapid tranquilisation 2.6 Advice and support for patients with acute severe adverse effects and overdoses |

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| UNIT 3 | <p>The law and psychiatry</p> <ul style="list-style-type: none">3.1 Overview of relevant law in Ghana, including criminal and civil law and the national insurance scheme3.2 Ghana Mental Health Legislation in more detail3.3 Association of psychiatric disorders and crime3.4 Psychiatric aspects of specific crimes: violence, homicide, sexual offences3.5 The workings of the court, prisons and the police in relation to psychiatric disorder3.6 Effective collaborative working between the CMHO, the Police, the courts and other law enforcement agencies |
|--------|---|

| CMHO1202 Community Mental Health Practice II (3 Credits) | |
|---|--|
| Course Aims | To enable the student to develop practical skills in case identification, supporting the care of patients in the community and conducting mental health education |
| Learning intentions | By the end of the course the student should be able to: <ul style="list-style-type: none"> • Identify cases which need referral on to other healthcare professionals or agencies • Work with others to support patient care in the community • Plan and implement relevant health education in partnership with other agencies, services, professionals and individuals • Support rehabilitation of the mentally disordered in the community |
| UNIT 1 | Deciding which cases to refer on Knowing who to make referrals to and how |
| UNIT 2 | Working with others, in practice, to support effective mental health care in the community |
| UNIT 3 | Providing mental health education in the community <p>4.1 Community organisation and participation</p> <p>4.2 Involvement of other organisations/agencies such as NGOs</p> <p>4.3 The role of CMHO and practising the role</p> |
| UNIT 4 | Rehabilitation <p>4.1 Concepts and principles of rehabilitation/long-term care</p> <p>4.2 Procedures used in rehabilitation:</p> <ul style="list-style-type: none"> a) medical b) psychological c) occupational d) social <p>4.3 Provisions needed for rehabilitation:</p> <ul style="list-style-type: none"> a) institutions b) day centres c) outpatient clinics <p>4.4 Provisions required for rehabilitation in the community:</p> <ul style="list-style-type: none"> a) appropriate accommodation b) suitable well-supported carers c) suitable occupation d) patients' adherence to treatment and care e) effective collaboration among carers f) regular assessment of physical health and psychosocial needs g) crisis intervention when the need arises |

| CMHO1203 Basic Clinical Psycho-Pharmacology (2 Credits) | |
|--|--|
| Course Aims | To enable the student to understand the use and adverse effects of medications that are commonly used in treating psychiatric disorders |
| Learning intentions | By the end of the course the student should: <ul style="list-style-type: none"> • Understand the basic principles of clinical pharmacology in psychiatry • Have basic knowledge of the indications of commonly used medications (and ECT) in the treatment of depressive disorder, bipolar affective disorder, schizophrenia, epilepsy, acute psychiatric emergencies and other common conditions • Recognise the side effects of medications commonly used in treating psychiatric conditions in Ghana • Understand the ethical and legal aspects of use and abuse of medications |
| UNIT 1 | Basics of psychopharmacology |
| UNIT 2 | Classes of medications used in psychiatry <ul style="list-style-type: none"> 2.1 Antidepressants 2.2 Antimanic agents and mood stabilisers 2.3 Typical/conventional antipsychotic medications 2.4 Atypical antipsychotic medications 2.5 Anti-convulsants 2.6 Rapid tranquilisation 2.7 Practice of Electro- Convulsive Therapy (ECT) and medications used in the applications of ECT: 2.8 Other medications used in psychiatry |
| UNIT 3 | Psychotropic medication side effects – recognition and basics of treatment. |
| UNIT 4 | Ethical and legal aspects |

| CMHO1204 Psychosocial Aspects Of Treatments (3 Credits) | |
|--|--|
| Course Aim | To enable the student to develop a basic understanding of and some basic skills in relevant psycho-social treatments used in psychiatric practice |
| Learning intentions | By the end of the course the student should be able to: <ul style="list-style-type: none"> • Demonstrate an understanding of the concepts, models and skills commonly used in psychological treatments • Demonstrate an awareness of ethical considerations in psycho-social treatment • Provide supportive therapy and apply problem solving skills in working with patients and family members/carers |
| UNIT 1 | Understanding and practice of skills commonly applied in psychosocial interventions To include: <ol style="list-style-type: none"> 1.1 The therapeutic relationship 1.2 Listening and talking 1.3 Emotional release 1.4 Restoration of morale 1.5 Suggestion and reassurance 1.6 Explanation and advice/providing rationale 1.7 Psychotherapies |
| UNIT 2 | Ethical issues in psychosocial intervention <ol style="list-style-type: none"> 2.1 Consent 2.2 Confidentiality 2.3 Importance of supervised practice |
| UNIT 3 | Treatments 1 <ol style="list-style-type: none"> 3.1 Individual interventions 3.2 Couples interventions 3.3 Family work 3.4 Group work |
| UNIT 4 | Treatments 2 <ol style="list-style-type: none"> 4.1 Crisis intervention 4.2 Problem solving 4.3 Supportive therapy |

| CMHO1205 Child Psychiatry, Learning Disabilities and Older Person Mental Health (3 Credits) | |
|--|---|
| Course Aim | To become familiar with how psychological/psychiatric problems present in children, the mentally retarded and elderly persons, and to understand the basics of care for these groups of people |
| Learning intentions | By the end of the course the student should be able to: <ul style="list-style-type: none"> • Identify and describe common psychological and psychiatric problems amongst children and adolescents, mentally retarded and elderly persons in the Ghanaian context. • Provide advice and refer children and adolescents, mentally retarded and elderly persons to appropriate services or agencies |
| UNIT 1 | Child Psychiatry <ol style="list-style-type: none"> 1.1 Normal development 1.2 Socio-cultural factors in childhood problems 1.3 Common problems in early childhood, middle childhood and adolescence 1.4 Assessment of child psychiatry problems 1.5 Child abuse 1.6 Psychosocial interventions in childhood and adolescence problems 1.7 Use of alcohol in children |
| UNIT 2 | Learning Disability/Mental retardation <ol style="list-style-type: none"> 2.1 Concept of mental retardation 2.2 Forms of disabilities and handicaps 2.3 Identification of the mentally retarded person 2.4 Physical, psychological, and emotional problems in the mentally retarded 2.5 Assessment of the disabled person 2.6 Psychosocial support for the mentally retarded and their family/carers |
| UNIT 3 | Mental health in the elderly <ol style="list-style-type: none"> 3.1 The effect of aging on mental health including losses, changes in physical health, loss of independence, roles, status 3.2 The effects of aging on physical health including: changes of metabolism and response to medication. 3.3 The presentation of common psychiatric disorders in the elderly including: depression, manic-depressive disorder and alcohol abuse 3.4 Degenerative brain disorders, including different types of dementia 3.5 Assessment of cognitive functioning 3.6 Detection and management of cognitive impairment 3.7 Management of behavioural and psychotic symptoms 3.8 Psychosocial and practical support for the elderly patient and their family / carers including working with other agencies |

| CMHO1206 Project Work (3 Credits) | |
|-----------------------------------|---|
| Course Aim | To demonstrate the competence to lead and implement a small scale intervention in the form of a mental health educational programme in the community which involves relevant professionals, opinion leaders and/or agencies. |
| Learning intentions | To develop the skill to conduct effective mental health education/promotion in the community. |
| UNIT 1 | The student will be expected to: <ul style="list-style-type: none"> a) Plan, conduct, evaluate and write up a small scale mental health education programme to demonstrate their competence in these areas b) Present their project work to peers and relevant stakeholders as appropriate. |

Appendix A

The Rationale for a Community Mental Health Officer

1. There is a global shortage of 4.3 million health workers (WHO “Working Together For Health” 2006). The most severely affected countries are those in Sub-Saharan Africa (SSA) which includes Ghana. When it comes to progress towards meeting the health related MDGs, again sub-Saharan Africa is significantly falling behind the other Regional Blocks (World Bank country report (2008) on human resource for health). Some of the reasons for such failures in the health sectors of SSA countries are:
 - Lack of access to basic health services
 - Inadequate environmental and sanitary standards
 - Inadequate number of health workers
 - Inappropriate skill mix
 - Lack of skilled health workers
 - Ineffective management coupled with inefficient ways of supplying logistics and pharmaceuticals.
2. In all of these, Ghana should be able to take a lead and find workable solutions to meet the ever changing needs of the populace. The wealth of a nation is the health of its people and therefore creating wealth through health is vital for any nation to make progress.

The rationale for increasing the number of mental health practitioners

High prevalence of mental disorder in Ghana and low treatment rates

3. There is a lack of comprehensive data on the incidence and prevalence of mental disorder in Ghana, but based on prevalence rates from the World Mental Health Survey 2004 it can be estimated that:
 - 13% of the adult population aged 18 and over (upto 2,816,000 people) are affected by mental disorder
 - 3% of the population (650,000 people) suffer from a severe mental disorder
4. Ironically, statistics from the health information systems in the country show that only 32,283 people are receiving treatment for a mental health problem. This comes to a treatment rate of only 2%, which is abysmally low. The bulk of the total population expected to have a mental disorder are not able to have access to care (Ref: WHO - Ghana Country Summary, 2007).
5. Globally, the contribution of mental disorders to the disease burden is expected to rise from a level in 2000 of 12% to about 15% by 2020 (WHO 2007). This presents a challenging situation for Ghana in relation to the level (and model) of mental health services that should be provided. Over reliance on institutional based treatment and care with its huge cost in the midst of other pressing demands on the health budget, brings to the fore a need to shift focus much more towards community based care

Mental health services in Ghana are sparse

6. In 2008, mental health services for the nation of 22 million people were provided at 68 health facilities only and most of these were in the south of the country. In 2008 these comprised:
 - 56 clinics run by community psychiatry nurses (CPNs)
 - 5 regional hospital psychiatry units with a total bed capacity of 77 (located at Ho, Koforidua, Kumasi, Sunyani, and Wa) (Ref MHaPP Country report- 2008)
 - 3 state-owned psychiatric hospitals in Accra, Pantang and Ankaful with a total bed capacity of 1550
 - 4 private psychiatric hospitals.
7. The 3 psychiatric hospitals in Accra, Pantang and Ankaful provide a total of 7.04 beds per 100,000 of the population.

Summary of Inpatient Mental Health Services

Accra psychiatric hospital (APH) has 800 beds but most of the time it is over-stretched and houses about 1,100 patients.

Pantang hospital (PH) located 25km east of central Accra has 500 beds whilst Ankaful psychiatric hospital (ANPH) near Cape Coast in the Central Region has 250 beds. Four percent (4%) of the total number of hospital beds in these hospitals are allocated to children and adolescents. All the three hospitals have mental health outpatient facilities.

Invariably, there is overcrowding in the state hospitals due to insufficient beds resulting in patients sleeping on mats and mattresses spread on the floor. In 2005 6,454 patients were admitted in these 3 state psychiatric hospitals. Psychotic disorders constituted the most frequently diagnosed condition followed by substance abuse disorders (mostly alcohol and cannabis related) and mood disorders.

At ANPH, the average length of stay of admitted patients in 2005 was 82.2 days whilst in PPH the average length of stay for the same period stood at 285 days.

Some mental health patients who are considered ready for discharge continue to remain in the psychiatric hospitals. The Mental Health and Poverty Project (MHaPP) study by Dr. Victor Doku, Dr. Akwasi Osei and others shows that, in 2007, 520 patients who were said to be ready for discharge at APH remained there. One of the reasons appears to be the stigma attached to mental disorders which results in families and caregivers abandoning their relatives at the psychiatric hospitals. It is likely that lack of community support and rehabilitation services also contributes.

Due to unavailability of or inadequate community rehabilitation centres for people with mental health problems, some of the patients in the state hospitals have virtually no support once they are outside the walls of the psychiatric hospitals. As one health worker put it, 'there are some of the patients who have gone in and out of hospital so many times that they prefer to stay permanently in the hospital'.

One patient for instance has been in a psychiatric hospital for over 20 years occupying a single bed.

The aforementioned among others point to the fact that we as a nation have not been able to meet the mental health needs of the people.

8. At primary care level, basic mental health conditions are seen at district hospitals by generalist medical doctors (not specialists in psychiatry) and Medical Assistants.

Mental health staffing shortfalls

9. In 2005 official figures showed that there were only 15 psychiatrists in Ghana. In 2009 the situation was no better. Out of this number, 9 were retired and on short term contract for limited working hours. 2 were in private practice whilst 4 were working in Ghana Health Service facilities.
10. When it comes to Community Psychiatric Nurses (CPNs), the picture is not too different. Most of the 132 CPNs in post as at 2005 will be retiring in the next 10 years, although efforts are underway to re-establish CPN training programmes.
11. Psychologists and social workers who also play a vital role in the management of patients with mental disorders are so few that they are unnoticeable. Currently, there are 0.004 psychologists and 0.027 social workers per 100,000 of the population respectively.

Workforce attrition

12. It is known that due to undesirable service conditions, mental health workers continue to move away from the field of mental health practice to general practice.
13. Preparing a well motivated and skilled mental health workforce with improved service conditions supported by an adequate budget will begin to reverse the poor state of mental health staffing and services for the population.
14. It is therefore important at this stage of our development to take into consideration the human resource for health development requirement for mental health alongside other priority needs. A lot more needs to be done by Central and Local Government, NGOs, Research, Education and training institutions as well as civil society to address mental health issues.

Moving away from institutional care

15. The policy of the Ministry of Health is now to shift the focus of mental health treatment from specialist institutional care in the large mental hospitals to community services and general health care settings throughout the country. This policy is clearly ripe for implementation.
16. The New Mental Health Bill strengthens community mental health services, helping those who need mental health care to be more easily identified and managed.
17. This move to a more community based approach, apart from reducing the cost of in-patient care, will also prevent the influx of persons to the three state run psychiatric institutions which are all located in the urban coastal cities of southern Ghana (Accra, Pantang near Accra, and Ankaful near Cape Coast). The policy will increase access to mental health care in the least restrictive environment as near to the sufferers' home as possible which are basic health care rights for the populace.

The rationale for the mental health workforce scale-up being through the creation of CMHO and MAP to support existing practitioners

18. Commitment to primary health care delivery in Ghana after independence led to the establishment of a Rural Health Service. This led to the training of a cadre of middle level health professionals known as health centre superintendents who were later on called Medical Assistants.
19. Today, much rural health care particularly in Northern Ghana is provided at health facilities staffed by Medical Assistants. They have become the backbone of the health system (Non-Physician Clinician study in forty-seven Sub-Saharan African Countries; Mullan & Frehywot, 2006).

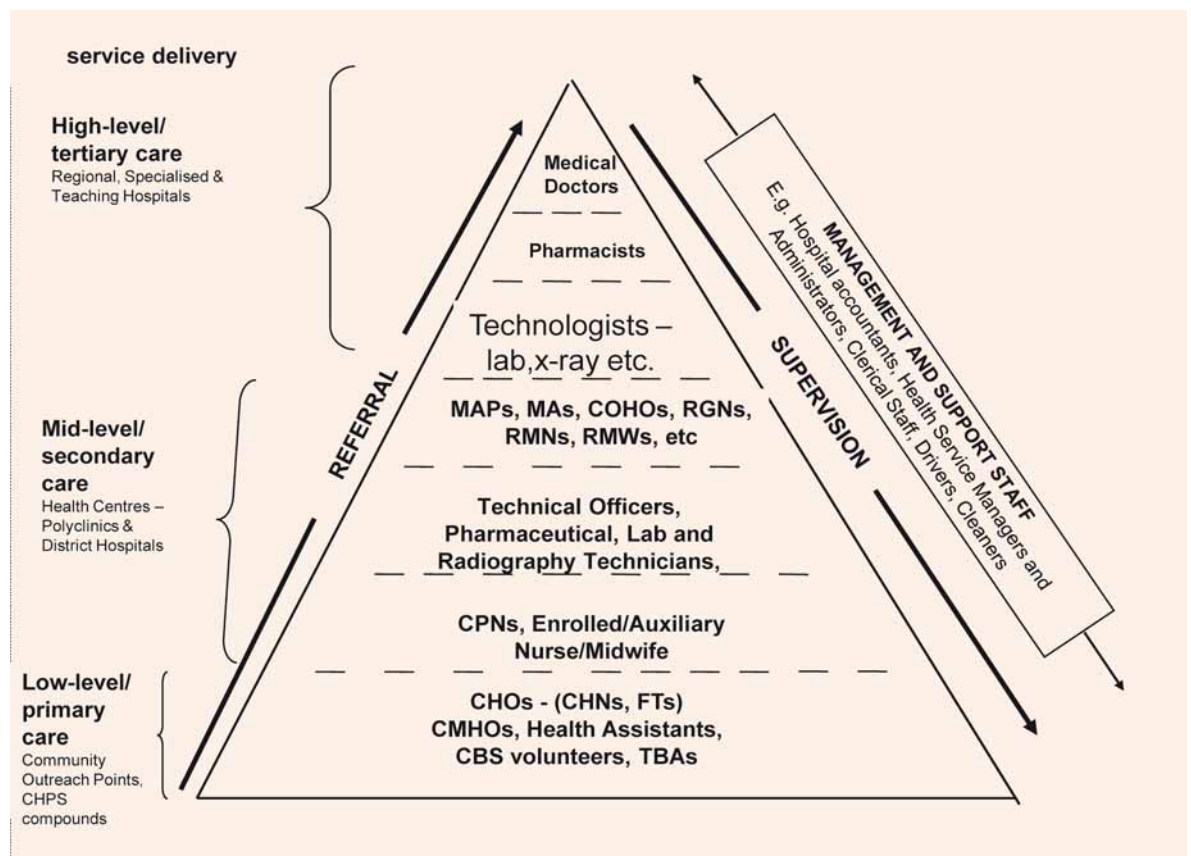
20. Despite the efforts being made since 1980 to train large numbers of health workers, the problem of shortage of physicians and other health professionals as a result of brain drain remains. Most district hospitals are under-staffed.
21. A review of training policies of MOH/GHS indicates the need to educate and train a specialist Community Health Officer who is well motivated to provide integrated health care mainly in the rural and underserved locations of the country. An underlying factor for the success of the 'CMHO/MAP/CPN' model of community mental health care is also to ensure adequate educational and professional career progression for CHOs and MAs to attain self-actualisation and self-esteem.
22. Community Health Officers with additional training in psychiatry will naturally fit into psychiatric practice alongside CPNs and MAPs. As certified health professionals who are already in practice CHOs are in an ideal position to use their public health orientated generalist knowledge and experience to support their specialist work.
23. The broad focus of CHOs on education and prevention will provide a solid foundation for their clinical practice.
24. A Community Mental Health Officer will be able to understand the diverse medical as well as the mental health needs of mentally disordered patients.
25. The CMHO will support the middle tiers of community mental health practitioners. CMHOs working without the middle tiers would be professionally isolated, overburdened and overstretched trying to support the mental health education and prevention needs of all those in the specialist field.
26. As the Community Psychiatric Nursing (CPN) model of community care will not be able to provide the ever increasing community care needs of the population alone the additional resource that will now be available is the CMHO and the specialist Medical Assistant Psychiatry.
27. The CHO's work within CHPS is described below.

CHPS (Community-based Health Planning and Services)

As a way of bringing health services closer to the 'door steps' of the populace in Ghana, a Community-based Health Planning and Services (CHPS) strategy was introduced. Community Health Nurses, Field Technicians, Midwives and other frontline health workers upon completion of their courses of study are given further training and designated as Community Health Officers (CHOs). They are posted to CHPS compounds to provide integrated services. Working as a team with Community Based Surveillance Volunteers (CBSV), Traditional Birth Attendants (TBAs) and Community Health Committee Members (CHCM), CHOs plan and manage health conditions and events covering the management of common ailments, growth monitoring and promotion, immunisation, family planning, antenatal & postnatal services, disease control and surveillance and health promotion among other duties.

28. It is estimated that several thousand (15,000 or more) CHOs will be needed in the next 5-10 years to sustain and move CHPS forward. In line with this and other developments, MOH/GHS has significantly increased the intake of CHO learners into training schools.
29. New schools have also been established to absorb more CHO trainees to be able to meet the human resource requirements.

30. The academic and professional career progression for CHOs to attain self-actualisation and self-esteem is vitally important for long term job satisfaction and workforce retention. An upgraded CHO, well educated and trained in the area of community mental health, resourced and supported to perform his/her duties will be highly motivated. Such an upgraded Community Mental Health Officer (CMHO) can be part of a multi-disciplinary team with the CPN and MAP and a wide range of allied professionals to provide mental health services in the community. This will bring about continuity of care and integrated services from the household/family through to the highest level of care.
31. CMHO, MAP and CPNs fit into the existing workforce as illustrated below:



Appendix B

Description of what the CMHO will do

Overview

1. The duties of the qualified Community Mental Health Officer are primarily focussed on supporting holistic mental health care at the community level along with the CPNs and MAPs. The CMHO practises in very close collaboration with existing health care professionals, particularly the Community Psychiatric Nurses (CPNs), Medical Assistant Psychiatry (MAP) and traditional and faith-based healers. They will work under the supervision of a Medical Assistant Psychiatry. The CMHOs will act within the formal code of conduct of statutory and professional associations. The CMHO will work with other relevant stake holders and cases will be referred as appropriate.

Intended workforce density

2. The workforce density will be determined by the Ministry of Health and Ghana Health Service

What does the CMHO do?

3. The CMHO will have less specialist psychiatric knowledge than CPNs and Medical Assistants in Psychiatry, so they will operate in a supportive role them. The MAP and CMHO will not treat the whole range of psychiatric conditions that exist because in the early years of the workforce scale up they would be overwhelmed and workforce retention would become a concern.
4. Evidence from the World Health Organisation and the series of publications on Global Mental Health in the Lancet in 2007 suggests that initial actions to scale up mental health services in low and middle income countries should consist of basic, evidence based packages of care and services for core mental disorders. These should be disorders which both contribute significantly to the burden of disease and have an evidence base for treatments which are effective and available.
5. With these factors in mind, key stakeholders, including the Chief Psychiatrist and other practising psychiatrists in Ghana, have concluded that CMHOs and MAPs shall be confined to managing the following conditions:

| Condition | ICD-10 code |
|---|------------------------------------|
| Schizophrenia | F20 and F22-F29 |
| Bipolar Affective Disorder ('manic depression') | F30 and F31 |
| Depressive Disorder | F32, F33 and F34.0 (but not F34.1) |
| Hazardous alcohol use | F10.1-F10.7 |
| Epilepsy | |

6. The first three are major mental disorders as defined in the WHO International Classification of Diseases (ICD 10).
7. Hazardous levels of Alcohol use are, on average,
 - >20g pure alcohol/day for women (1 bottle beer / day)
 - >40g pure alcohol/day for men (2 bottles beer / day)

Alcohol dependence syndrome is also defined by the WHO ICD 10

8. Epilepsy is included because currently it is treated by psychiatrists and where there are no psychiatrists it is treated by general doctors. Although it is treated by neurologists in Western countries the inclusion of epilepsy for CMHO is not unreasonable as people with epilepsy, at a community level, face many of the same problems as those with mental illness. A community mental health service such as the CMHOs, CPNs and MAPs will operate in a way that can meet those needs. Furthermore, neurologists are even scarcer than psychiatrists in Ghana.
9. Treatments available for the 5 conditions have an evidence base. The treatments consist of:

| Disorder | Main evidence based treatments |
|----------------------------|---|
| Schizophrenia | Antipsychotics and psychosocial support |
| Bipolar Affective Disorder | Mood stabilisers and psychosocial support |
| Depressive Disorder | Antidepressants and psychosocial support. |
| Hazardous alcohol use | Detoxification and brief psychological interventions. |
| Epilepsy | Anticonvulsant medication. |

10. CMHOs, CPNs and MAPs will also give psychological and social support for the families and carers of patients. They will work closely with the community, providing education about mental disorder and will have links with groups such as the police, churches, traditional healers and schools.
11. Regarding other conditions that CMHOs and MAPs may come across, the following pertain:
 - **Non Schizophrenic Psychoses e.g. Organic Psychoses and Drug Induced Psychoses.** MAPs should be able to diagnose and manage the acute presentation of these conditions. They would be expected to refer organic psychoses to a physician and provide some input in the acute phase. They should be able to distinguish Drug Induced Psychoses from Schizophrenia but not to provide long term management due to limited treatment options and workload considerations.
 - **Other Substance Misuse problems.** It is recognised that drug abuse such as cocaine and cannabis is a growing problem in Ghana. However, limited resources and lack of available treatments mean that, in the early years of the service, CMHOs and MAPs should confine their work to alcohol detoxification.
 - **Anxiety Disorders.** Due to large numbers of potential cases and limited effectiveness of available treatments these would not fall within the CMHOs and MAPs remit. They would be expected to recognise these as a category and refer on using protocols as a guide.
 - **Learning Disability / Mental Retardation.** The expectation would be to recognise and offer advice. Ongoing treatment would not be available
 - **Dementia.** These cases would be referred on to a psychiatrist for further treatment of any reversible cause, again with the aid of protocols.
 - **Child Psychiatric Disorders.** Only children above the age of 12-14 will be treated by MAP / CMHO at this stage. Treating children is quite technical and will be for psychiatrists until the MAP / CMHO workforce expands.
 - **Status Epilepticus.** This is a medical emergency and will be managed by Medical Officers (MO) or Medical Assistants (MA) in the first instance, unless no MO or MA is available. Psychiatric in-patients who suffer status epilepticus would be managed initially by a MAP.
12. CMHOs can ask MAPs or CPNs for help for any cases for which they are having difficulty deciding what to do. They can contact MAPs by mobile phone, face to face at the District Health Centre or could raise issues during supervision.

13. Support - Whilst the benefits of restricting the CMHO's and MAP's work are clear, there will undoubtedly be many challenges. Practitioners may be working in relative isolation and face pressures from within the service, as well as from patients and families. This could lead to difficulties maintaining boundaries, such as who to treat and for how long. Add to this the diagnostic uncertainties there will be and it can be seen how working within strict guidelines may prove difficult at times. To help manage this, specialists in Hampshire Partnership NHS Foundation Trust in partnership with experts in Ghana will provide long term support for CMHOs and MAPs.
14. The future - Looking to the future it can be expected that with workforce and service development, the remit of CMHO and MAP will expand. Some of the limitations faced now are due to lack of resources and available treatments. Changes and improvements will lead to CMHOs and MAPs being able to treat a wider range of conditions in the future. In time, as more practitioners qualify, strengthening the workforce and developing the service, it is hoped that CMHOs will develop a wider range of specialist skills. They will eventually be under less pressure to practise as generalists alongside their specialist role thus allowing room for their practice to expand. This, and their continuing professional development, will give CMHOs scope to manage psychiatric disorders outside the five core conditions. A longer term vision of developing routes for career progression may also provide opportunities for sub specialist qualifications in mental health and subsequent expansion of roles.
- 15 At the end of the programme, a Community Mental Health Officer should be able to undertake administrative, support duties and clinical duties in line with their qualification as CMHO. These include:

Administration

- Supporting MAP and CPNs to manage mental health services at community level
- Supporting MAP and CPNs to organise and supervise mental health activities at district level and below
- Attending any relevant planning meetings relating to mental health issues
- Compiling records and providing information needed by MAP for the writing (by MAP) of monthly reports on mental health cases for submission to the SDHT and DHMT
- Supporting MAP to prepare and disseminate reports on PHC mental health related activities.
- Conducting occasional research into mental health problems in the district and disseminating the findings as part of problem solving activities.
- Collecting data on mental health cases in the community for analysis and use for decision making
- Assisting with the management of medications, equipment, materials and other resources for mental health activities.
- Having an understanding of national health policy and its relevance to mental health.
- Recognising the role of other sectors in contributing to community mental health
- Assisting MAP and CPNs in the management of general health and mental health information systems
- Participating in PHC activities
- Performing any other function that may be assigned as and when required by line managers

Training

- Conducting mental health training needs assessment and training other health workers

Clinical

- Identifying people suffering from mental health problems (this covers the whole range of possible mental health problems a person could suffer from – not just the core conditions)

described in earlier paragraphs) but with a specific focus on those mental disorders prioritized for treatment by MAP. The CMHO does not formally diagnose psychiatric disorders.

- CMHOs do not prescribe medication or carry out any other independent form of treatment. However, they do supervise medication prescribed by MAP or doctors.
- CMHOs will undertake preventative / educational counselling and might occasionally undertake some aspects of counselling for treatment, under supervision.
- Helping mentally ill people and their families to seek and receive care and support. This statement does not imply *providing care* for these people, it concerns helping them to receive care and support. Many such people will be referred on elsewhere eg to MAP, CPNs, psychiatrists or other services eg drug abuse treatment centres, learning disability services etc (as CMHO will not be responsible for making diagnoses they might need advice from MAP before being able to help clients at this stage).
- Supporting the administering of treatment plans for mental disorders as described in paragraphs above.
- Supporting the management of mental disorders in the community – limited to the range of conditions described in paragraphs above
- Understanding the beliefs, value systems and culture of the communities served.
- Promoting mental health through collaboration and networking with other sectors
- Working with other members of the health team, other agencies/organizations and the community to plan, implement and evaluate health activities.
- Ensuring that mentally ill people who need assessment by MAP, CPNs or a psychiatrist actually attend and receive their assessment
- Planning and conducting mental health education programmes in the community
- Promoting the national achievement and maintenance of good mental health

Continuing professional development

- Maintain and update professional practice by undertaking continuous professional development (CPD).
16. The CMHO and MAP do not provide complex psychotherapies. Simple supportive psychotherapy will be provided by MAP including ‘counselling’ and illness education, but not psychotherapies such as CBT, DBT etc - these therapies will only be available from either psychiatrists or other practitioners with specific training for their provision.
 17. MAP prescribing will be from a broad but restricted range of medications. For example, it will not include prescribing narcotics or amphetamines for mental health problems.

Who does the CMHO work with?

18. The CMHO has key relationships with:
 - Medical Assistants in Psychiatry
 - Community Psychiatric Nurses
 - Psychiatrists
 - Medical Officers
 - Other health professionals in the community
 - Patients and their family members
 - Community leaders
 - Social workers
 - Traditional healers and church leaders

- Police
- Prisons
- NGOs

(note – there will be others too, this list is not exhaustive, it is just a guide)

Where do CMHOs work?

19. The priority is provision of services to rural and semi urban communities. CMHOs will mainly operate from community and sub-district facilities.

What is the supervision framework for CMHOs?

20. Supervision is provided by MAPs

What are the line management arrangements for CMHOs?

21. These are determined by MoH / GHS

Resource requirements for CMHOs

22. The resources needed by CMHOs are determined by GHS and local arrangements. Absolute priorities will include (this list is not exhaustive):
- Domestic accommodation
 - Office space
 - Means of transport (a motorbike)
 - Means of communication
23. Transport is crucial as CMHOs are fully community based. Each CMHO requires the use of a motorbike without which their practice would be severely restricted

Values underpinning the practice of CMHOs

24. CMHOs have obligations to their patients, to society and their chosen profession. This requires commitment to life-long learning and continuing professional development.
25. CMHOs are professional practitioners who:
- Show respect and see patients as a whole, not just a 'disease' or 'condition'
 - Understand and acknowledge the ethical, cultural and socio-economic context of the person
 - Foster relationships of trust, honesty and understanding between practitioner and patient
 - Establish clear and empathic communication that will promote understanding and partnership
 - Develop professionally and practise within the scope of expected competence
 - Form the habit of reflecting on issues and occurrences in quest of deeper understanding, knowledge and good practice.
 - Are both team players and have the ability to practise with autonomy within the structure and framework of professional practice.
26. CMHOs will uphold the principles of the clinical professions, particularly the medical professional principle of 'first do no harm'. An important implication of this is that there is no automatic assumption that western approaches to health practice are superior to traditional practices. Many traditional practices can be as good as and sometimes better than western approaches for some conditions, so all cases will be treated individually. The mental disorders that CMHOs will primarily treat are those which are safer managed by western medical treatments.

Appendix C

Guidelines for Assessment, Examination and Grading of Students

1. Assessment shall be both formative (to help the student understand their progress, so that they can plan their future learning) and summative (for teachers/assessors to determine the student's progress/level).
2. Assessment shall be continuous, playing a fundamental role in the teaching/learning process. It takes into account the professionalism, education, values, attitudes, knowledge and skills of the student and the needs of the employer. The assessment process is subjective and there is no single method that will overcome this. The professional judgement of the teacher or preceptor will always be a key component of the process. In order to be fair, teachers and preceptors shall make on-going judgements of the teaching/learning process and such judgements are part of a well planned process producing multiple perspectives. A range of assessment methods (including case studies, short tests, field work report, reflective accounts of practice, observations, mid semester examination, end of semester examination, licensure examination) will be used. The units of the curriculum content will be assessed based on aims and learning intentions set. The role of assessment therefore is to:
 - Ensure the appropriate development of the student. It shall cover any of the situations in which aspects of the student's education are measured, recognised or formally appreciated by teachers, preceptors or the students themselves.
 - Demonstrate how well and in what ways the student has profited from learning opportunities as reflected in their self knowledge and deliberation with those who teach them.
 - Allow students to integrate and or link theory and practice.
 - Allow students to demonstrate creative approaches to knowledge and understanding.
 - Inform and shape the understanding of both teacher and student about the student's progress and achievements
3. All the assessment methods will allow the learners to integrate theory and practice.
4. Professional practice related skills will be assessed through skills and practice based assessments.
5. The academic tutors, clinical supervisors and preceptors will play a key role in facilitating learners' ability to make links between theory and practice.
6. The assessment of each unit will be based on the learning outcomes.
7. Students will receive constructive feedback for each assignment from teachers and peers.
8. Students will be required to successfully achieve and complete practice based clinical competencies within each unit.
9. The expected competencies are outlined in an Assessment of Practice (AOP) document.
10. The assessment of professional practice will be part of the academic credits accrued. This forms an essential component of the requirement for the successful completion of the programme.
11. In recognition of the need to properly assess, examine and grade students in accordance with the structure and content of the curriculum, the school hereby provides the following guidelines to regulate the summative assessment, examination and grading of students:

12. Purpose of assessment/examination

- To assess the effectiveness of teaching.
- To determine the level of learning that has taken place (i.e. students 'mastery of lessons planned and implemented in the curriculum)
- To provide the basis for:
 - Repetition of instructions in specific areas not well understood by students.
 - Promotion, referral, demotion or dismissal
 - Satisfactory completion of programme (course of study)

13. Types of assessment/examination

The types of assessment/examination conducted in the school include:

- Assignments
- Periodic class tests
- Quizzes
- Assessment of competencies
- Assessment of portfolios
- Case studies
- Viva voce
- Mid-semester examination
- End-of-semester examination
- Professional examinations (theory, practical & oral)

14. Method of assessment/examination

The various methods to be employed include:

- Objective questions
- Essay questions.
- Demonstration of competence in practical skills
- Demonstration of satisfactory portfolio
- Viva voce

15. Preparation for assessment/examination

It is mandatory for students to be ready for and participate in all assessments and examinations in the academic calendar and as and when determined by tutors.

A week prior to assessment/examination students will be informed orally for minor examinations and by prepared timetable for major examinations.

Students must possess their own materials for assessment/examination unless instructed otherwise by tutors or the school's Academic Board. Students are permitted to use the following during an assessment/examination:

- Mathematical set (should not contain any paper)
- Pen(s)
- Pencil and sharpener
- Eraser
- Ruler
- Watch
- Scientific calculators (please take note that mini-computers/organizers, any calculator having the letters A-Z on it and mobile phones are not permitted. They will be confiscated if found).

16. Qualification for Assessment/Examination

If a student misses more than 25% attendance for a subject, he/she does not qualify to be assessed/examined in that subject.

17. Conduct in Examinations

Students must take note of the following during assessment/examination:

- No student should have on him/her any material not permitted during assessment/examination.
- No student should bring any type of book/notes into and around the venue of the assessment/examination.
- No student should attempt to communicate in any way with another student. All matters should be communicated to the tutor/invigator.
- No student should attempt to borrow any material from another student.
- No student should attempt to take any answer sheet/booklet, either unused or spoilt out of the venue of the assessment/ examination.
- Students should make it top priority to write their index numbers on all answer sheets/ booklets used during an assessment/ examination. Any answer sheet/booklet without an index number cannot be traced to the owner and therefore will be discarded.
- Students are advised to draw the attention of the invigilator/ tutor when they discover any act of misconduct by other students during an assessment/examination.

18. Sanctions

Any student found contravening any of the rules and regulations regarding assessment/examination will be expelled from the venue of the assessment/examination and sanctioned appropriately. In this regard, invigilators/tutors have the mandate to take the most appropriate action on the spot and report to the Academic Office for further action to be taken.

19. Licensure Examinations

These are conducted by external examiners for students who have passed all courses (subjects) at the end of a programme of study. They are in two parts – mock and final.

The mock is organized to prepare students for the final professional examinations.

Any student whose average score for all papers taken falls below 50% will be considered to have failed the entire examination.

Any student who is referred in any paper will be given the opportunity to re-write that paper within six months upon declaration of results.

Students have three chances to pass a referred paper.

Appendix D

The Educational Principles Underpinning the Design and Structure of the CMHO Curriculum

This curriculum document describes the education considered necessary to help create the new CMHO workforce, and provides a statement of its underlying educational principles, which include the following:

The interdependence of education, service and workforce

1. This curriculum design is determined by the crucial interdependence of:
 - a) the **education** being provided for CMHOs
 - b) the clinical **services** that currently exist and those that will develop as the roles of CMHO fully unfold when they are in post
 - c) the current workforce and the emerging **workforce** (MAP, CMHO, RMNs, psychiatrists etc) to provide those services.
2. The curriculum design recognises that any one of the above – whether education, service or workforce – cannot develop appropriately or satisfactorily in isolation from the other two.

Determining what the practice of CMHO should be

3. In 2010 when this curriculum came into existence there were no Community Mental Health Officers (CMHOs). Community Mental Health Officers were a new cadre of mental health professionals being introduced alongside the (also) new Medical Assistants in Psychiatry (MAP). The students therefore had no role-models to follow and no established practice to emulate. Although there is a vision for the intended practice of CMHO, it is part of the education for CMHO within this curriculum for the CMHO students to develop their understanding of what their practice will be, and (crucially) what the actual best role of the CMHO is. This will be learnt/developed by CMHO as their learning unfolds (as it is likely that the intended practice of CMHO as described earlier will eventually modify as CMHO practice develops and embeds). The full details of the knowledge, skills and expertise CMHOs will need will only be known once CMHO practice becomes well understood which will begin in earnest once the first cohorts of CMHO actually start to practise
4. This uncertainty and the necessarily 'developmental' perspective is important for both students and teachers of KRHTS to appreciate and understand. It has critical significance for the design of the curriculum and the associated translation of the curriculum design into action through the educational work being carried out in KRHTS and on clinical attachments, visits and placements. Some details of what may be required are given below. Others however will emerge as the curriculum is translated into practice. Because of this the curriculum design is a 'work-in-progress' and will be for many years to come. It does and will require continuous evaluation, review and renewal.

Practice based learning

5. The programme is predominantly (70%) practice based learning, because the students are mature practitioners who are already qualified. They have already been in clinical practice and are experienced.

CMHOs are self directed learners

6. The students shall act as 'self-directed learners' for as much of the programme as possible. This contrasts with undergraduate courses which cannot have such a strong self-directed focus. This self directed learning will be facilitated by course tutors and placement preceptors.

The learning and teaching framework will include the following:

- Students will undertake observation in clinical settings so that they can learn to see, analyse and interpret mental health clinical practice
- Students will learn the processes of reflection, self-knowledge and self appraisal.
- Small group activities will encourage students to test ideas in a safe and supportive environment
- Practice based learning activities will facilitate students to develop a wider sense of belonging
- Students will be exposed to problem solving and problem based learning approaches to enable them to identify and propose solutions to problems in the areas of mental health, educational and social issues.

Principles guiding the curriculum content

7. Mental health (and non-mental health) practitioners in Ghana and the UK have been consulted concerning the practice / service required of CMHO. This has included doctors, nurses, medical assistants and policy makers in Ghana.

Appendix E

Arrangements for Placements (Clinical Visits and Attachments) and Work in School

The CMHO programme is predominantly provided via practice based learning on placements (clinical visits and attachments)

1. The main place for learning CMHO practice is in the practice setting (on placements, clinical visits and attachments). Classroom teaching in school is aimed primarily at supporting the learning in the practice setting.
2. The balance of time the CMHO students spend 'in school' (at KRHTS) versus time on supervised placement has been set (in the first instance and for a trial period) at a ratio of 30% 'in school': 70% on placement.
3. Individual students meet with their supervising tutor/mentor to review and discuss progress. Both keep written records of these meetings – students in their portfolio (see below): tutors in their student records.
4. Students' written examinations are conducted in school (see below).
5. Decisions about the students' progress (how they are getting on) and progression (whether or not they should proceed/graduate) are taken in school (see below).

'In school'

6. The general purpose of the 30% of students' time spent at KRHTS ('in school') is:
 - to introduce the students to the aims of the programme, its intentions, structures, processes, procedures and requirements
 - to prepare students for their work in supervised placements
 - to provide students with study material (see below)
 - to provide resources for placement preceptors (see below)
 - for students to work in learning groups to debrief on their work from their practice placements, facilitated by their school tutor(s)
 - to offer occasional lectures to students on relevant topics provided by visiting/outside speakers.
 - to arrange appropriate examinations to assess and record students' progress and achievements
 - to provide support for students through tutorial, mentor, remedial procedures
 - to evaluate the programme for developmental and regulatory purposes.

Some of the work in school occurs in 'whole group' sessions, with all students together (either the entire year group of CMHOs and MAPs or separate groups of CMHOs and MAPs as necessary).

'In practice' (clinical placements)

7. The general purpose of the 70% of students' time spent on placements is:
 - to provide experience of and exposure to mental health practice

- for practical engagement in the provision of mental health services
- to offer support for students' clinical practice and learning through the provision of appropriately qualified and trained supervisors and good supervisory processes.
- to make provision for students to gain access to settings where community mental health is needed, such as schools, workplaces, residences, the police and public places.

Placement locations

8. The location of placements includes:
 - health centres
 - CHPS compounds
 - district hospital
 - regional hospital psychiatric departments
 - national psychiatric tertiary hospitals

Placement rotations and experience

9. Students rotate between practice placements in blocks of time, interspersed with blocks of time at KRHTS. Students also gain practice experience through day release placements (field site visits) whilst 'in school'.

Experience gained by CMHO on placements

10. On placements, students gain experience of, and begin to develop their practice in:
 - public education
 - case finding
 - support for out-patient care
 - support for community care
11. During placements, students gain experience and develop a significant understanding of the contribution made by other providers of mental health care, including:
 - traditional healers
 - prayer camps
 - schools
 - the police
 - community leaders and groups

Developing CMHO practice

12. Through their work both in school and on placements, students develop their capacity to:
 - understand existing systems and procedures for mental health care where this is not currently provided by state services
 - liaise with existing providers of mental health care (including 'traditional' and other providers) to create working partnerships for the benefit of clients, their families and those who care for them.
 - develop links (and where these do not currently exist, establish links) with other professional carers at district, regional and national levels.
 - establish and develop appropriate links with MAPs within their practice areas.

13. Students mainly gain their 'formal knowledge' through written material, including copies of published texts, monographs and review articles, although where facilities exist students are encouraged to also use the internet.
14. Resource material will be developed by specialist teachers and made available (some through electronic media such as CD-ROMs and DVDs). Where this material replaces the need for lectures it will reduce the need for lecturers and lecture accommodation. The general principle in this curriculum is that if a topic can be given as a lecture then it can be presented in an electronic or written form for personal and group study instead.
15. Students require access to computing facilities (most conveniently through portable 'lap-tops') eventually individually but initially through sharing.
16. Some knowledge necessary for effective practice is not found in published texts, and some cannot be defined in advance of students engaging in clinical practice. This is known as 'practice knowledge'.
17. Sources of practice knowledge include the 'know how' of existing practitioners and providers of health care. CMHO students are expected to explore, unearth and capture this knowledge through their studies in the practice setting.

The role of the teacher and learner in the learning - teaching process

18. The teaching-learning interaction involves the teacher/supervisor/placement preceptor and the learner (the student). In the course of the interaction both the teacher and student seek and share knowledge. The teacher is seen as a facilitator for the student and a leader within the group.

The role of the teacher

19. The teachers should be able to:
 - Create conducive learning environments and facilitate the learning
 - Encourage students to explore
 - Stimulate students to think critically
 - Stimulate students to reflect on professional practice.
 - Encourage participatory learning
 - Assess the work of students (using case studies, reflective accounts of practice, professional conversations, essays, examinations, and assessment of practice capability).

The role of the learner

20. The learners should be able to:
 - Participate in learning
 - Seek knowledge independently
 - Seek and share knowledge in collaboration with all stakeholders in the teaching and learning process
 - Communicate effectively both in writing and orally
 - Aspire to become competent
 - Explore and further develop professional practice
 - Assess their own work (self-assessment and group assessment)
 - Critique their own work

Arrangements for placements

21. Students work and study together on placements in 'learning groups' of three to eight students.
22. Placement 'learning groups' comprise a mix of CMHO and MAP students.
23. Group study is facilitated by a preceptor.
24. Other practitioners in the practice setting also provide input to the group's study as appropriate.
25. An example of a typical weekly programme is as follows:

| | Morning | Morning | Afternoon | Afternoon |
|------|---|--|---|---|
| Mon | Orientation Meet preceptor Plan week's activities | Meet staff and other activities | Ward based work (e.g. see patients take histories) | Small group session Case presentations to each other |
| Tues | Ward based (e.g. see patients shadow staff) | | Community based visits (e.g. with CPN or other staff) | |
| Wed | Local visits (e.g. police station, prayer camp) | Reflective group discuss prompts Present Plan activities | Ward or community See patients Interview families Work on tasks | |
| Thur | Ward or community | | Group session with preceptor Formal teaching by students to the group Case presentations Discussion group Reflective practice/writing | |
| Fri | 1:1 with preceptors Review week Plan next week | Ward or community | | Writing up |

26. Students access resources (textbooks, monographs, review articles, CD-ROMs, DVDs, internet searches, etc) as and when they need to understand more fully what they are experiencing in the practice setting. Placement preceptors help facilitate students to study and learn this way (see preceptor development below).
27. Students are encouraged to share and discuss (with each other and their teachers) their experiences, their developing knowledge and the content of resources they access. They discuss their understanding of this and its significance for both the immediate clinical and organisational problems they are experiencing in their clinical placement and for their longer term development as practitioners.
28. Students capture their learning through extensive use of a portfolio (see below).
29. Students' placement work is assessed by their preceptors (see below).
30. Work undertaken on placement is part of their overall assessment

Appendix F

Management of the Programme and Recruitment

Who Manages the Curriculum?

1. The curriculum is managed by Kintampo Rural Health Training School (KRHTS). KRHTS is one of several health training institutions under Ministry of Health (MOH) in Ghana. It is only one of its kind in the country. Currently, each health training institution, with the available material and human resources, manages the curriculum for each programme in close consultation with MOH headquarters in Accra, specifically the human resources division, and other stakeholders like the Ghana Health Service (GHS).
2. Since 2002, MOH headquarters has been organising meetings for heads (as representatives) of the training institutions and its (MOH headquarters) staff to consider overall management issues of the institutions, including that of curricula. Therefore issues pertaining to curriculum management are considered and conclusions arrived at within the context of the individual institutions. The decisions are informed by communities, local problems and the needs of the health sector.

KRHTS context

3. KRHTS currently has nine programmes running and has structures (both material and human) in place managing each of the curricula of the nine programmes. The Community Mental Health Officer (CMHO) programme is integrated into these structures.

Entry requirements and recruitment processes for the CMHO programme

Background

4. KRHTS has (in 2009) two main entry groups depending on the nine programmes offered. These are:
 - a) Senior High School leavers for the following programmes:
 - Technical Officer Health Information Diploma programme (3yrs duration)
 - Technical Officer Disease Control Diploma Programme (3 yrs duration).
 - Technical Officer Nutrition Diploma programme (3 yrs duration)
 - Technical Officer Laboratory Technology Diploma programme (3 yrs duration)
 - Dental Surgery Assistant Diploma programme (3 yrs duration)
 - Field Technician Certificate programme (2 yrs duration)
 - Direct Medical Assistant Advanced Diploma programme. (4 yrs duration)
 - b) Health Professionals in service:
 - State Registered Nurses (SRNs) and Registered Mental Health Nurses (RMNs) for the Advanced Diploma Post Basic Medical Assistant (PBMA) programme.
 - State Registered Nurses (SRNs) and Registered Mental Health Nurses (RMNs) for the Advanced Diploma Post Basic Community Oral Health Officer (PBCOHO) programme.
 - Field Technicians (FTs), Community Health Nurses (CHNs) and Environmental Health Assistants

(HIAs) for the Technical Officer Communicable Disease Control Diploma programme.

- Field Technicians (FTs), Community Health Nurses (CHNs) and Environmental Health Assistants (HIAs) for the Technical Officer Nutrition Diploma programme.
5. Due to the urgent need for the CMHO health professionals and the short duration of the programme, the entry group for the start of the programme will be Field Technicians (FTs), Community Health Nurses (CHNs) who have served two years minimum of service in deprived areas or three years minimum of service in areas not deprived.

Recruitment processes

6. Recruitment processes are the same as those used for all courses at KRHTS. They will take place during the 5 months running up to each programme intake.
7. The following steps apply:
- **Advertisement:** The Ministry of Health, via KRHTS inform potential entrants by advertising in the most widely circulated national news papers (Daily Graphic and the Ghanaian Times). Copies of the advertisement are also displayed on notice boards in the KRHTS.
 - **Submission of an application form:** The advert directs prospective entrants to buy, complete and submit an application form.
 - **Entrance examination:** nil
8. **Selection Interview:** This is organised by KRHTS.
9. Candidates with a score range of 50 – 100% are selected for admission.
10. The areas for scoring at the interview are:
- Commitment to practising in mental health
 - Appearance and behaviour (including evidence of composure and good character)
 - Current Practice (including experience and team work)
 - General knowledge and life experience
 - Academic ability to complete the programme
 - Commitment to pursue the programme
 - Commitment to professional practice
 - Communication skills
11. Particular weight is placed on character, communication and commitment to mental health.

Appendix G

Resources

Location of the programme

1. The CMHO and MAP programmes are based at the Kintampo Rural Health Training School in the Brong Ahafo region of Ghana.

General Administration

2. The Director is the overall administrative and academic head of the institution which is sub-divided into:
 - Day-to-day administration: headed by Deputy Director for Administration supported by a secretary.
 - Finance: Headed by an Accountant supported by two accounts clerks.
 - Academic: Headed by Deputy Director for Academic Affairs supported by teaching staff, academic committee, programme heads and fieldwork coordinator.
 - Student Welfare: Headed by Dean of Students supported by housemasters, tutor in-charge of sports and entertainment, catering committee, disciplinary committee and Students Representative Council.

Physical Facilities

3. The school has a wide range of facilities including administrative block, store blocks, hostel blocks, a Catering Unit, a Library block, a computer laboratory, classrooms, skill laboratories, internet connectivity (non-functional), conference room, meeting room, vehicles.
4. Placement ('field' / attachment) facilities are not described in this curriculum.

Teaching Staff

5. There are full time teachers in various disciplines, many part time teachers and preceptors both within and outside the country to assist with teaching. There are permanent teaching staff with mental health background for the CMHO and MAP programmes.

Teaching and learning materials/aids

6. range of audio visual aids are available at KRHTS including laptops, LCD projectors, overhead projectors, television sets, video cassette players, video recorder and digital camera.

Placements

7. These will be at various facilities throughout the country.

Appendix H

Administration and Education Structures

Programme Head

1. There is a CMHO Programme Head at KRHTS. For further details please contact the school.

Educational support for teachers

2. Teachers are key stakeholders in curriculum design and development. MoH and KRHTS recognise this through capacity building strategies to upgrade its teachers both in teaching methods and management. Teachers are granted study leave with pay and sponsored to go through first and second degree programmes related to their professions, in universities in Ghana and outside Ghana. They also attend workshops, seminars and short courses.
3. The institution is accredited to award diplomas. A capacity building strategy is on-going and the CMHO programme will be part of this. Through its aim to attain a university status teacher capacity building at KRHTS is also focusing on higher degrees (Masters and PhD) in education. This is being supported by external collaborations such as that between MoH, KRHTS and Hampshire Partnership NHS Foundation Trust project. Teachers may also train at the Education Department of the University of Winchester for capacity building.

Appendix I

Quality Assurance Procedures

1. Quality Assurance (QA) is important in every endeavour.
2. To ensure quality of the CMHO programme:
 - A programme head is appointed to coordinate and manage the programme.
 - A programme committee will be formed of all staff teaching on the programme and at least one student representative who will bring student concerns to the committee and feedback to the students on the programme. The committee will meet at least once each semester to ensure the smooth running of the programme.
 - The curriculum will be reviewed, by the collaborative efforts of all stakeholders, as and when the need arises but by formal review every 5 years.
 - Appropriate recruitment and admission policies will apply.
 - An assessment policy including marking and moderation procedures will be produced.
 - An academic misconduct including plagiarism policy and a student complaints policy will be developed.
 - Appropriate educational opportunities will be provided to build capacity of tutors, preceptors, clinical instructors, mentors and other stakeholders, including preceptor training at least annually and the opportunity to develop personal research.
 - A process of annual staff peer review will be introduced.
 - The collaboration of key stakeholders will encourage multidisciplinary teaching and learning.
 - There will be ongoing monitoring and evaluation especially of performance of teachers and learners. This will be aided by a process of annual reporting by the programme head to the Academic Board, which will include written student, tutor and preceptor evaluations. The format and process for this annual monitoring will be developed.
 - External examiners' feedback and feedback from the report received from Ministry of Health-Ghana, Hampshire Partnership NHS Foundation Trust, University of Winchester, Service Managers, Regulatory Bodies, General Public (users, non-users, relatives of users), and National Accreditation Board will be sought.
 - Adequate and appropriate teaching and learning resources will be provided.
 - Learners will be licensed to practise and regularly reviewed.

Appendix J

Evaluation Of The Programme

1. Curriculum evaluation is part of the total process of curriculum design and development. Its purpose is to show how effective the curriculum is and ways in which it can improve.
2. The evaluation will take into account a wide range of perspectives covering all aspects of the programme through qualitative and quantitative methods. It will focus on the aims and expected learning outcomes of the programme and the use of and effectiveness of the opportunities provided in order for this to be achieved. The success of the programme may be known when the educational aims and the learning intentions are met and the learner (CMHO) can demonstrate competence thereof.
3. The evaluation will be managed by an internal steering committee (academic and governing board of the school, learners representative, representatives from district and regional health directorates, traditional and alternative medicine council, department of social welfare and criminal justice) and an external oversight committee (Ministry of Health, National Accreditation Board, and Regulatory Body). The internal committee will continuously evaluate the programme, and, on a yearly basis, send copies of their report to all relevant stakeholders. The committee will focus on the initiation of the curriculum, through the design and implementation and any other aspect of the programme that the committee deems necessary. The external committee will evaluate the programme at 3–5 years interval and send copies of their report to all relevant stakeholders.
4. The key question the evaluation team will be asking is in what ways the curriculum design, including its aims and processes, is being translated into practice. It is important that the evaluation team clarifies and discusses as widely as possible the purpose of the evaluation and the methods used to all those who will be part of the evaluation. The evaluation team should ensure confidentiality and at least anonymity to all those they will encounter as part of the evaluation.
5. During the evaluation, the team will:
 - review minutes of meetings of the curriculum design team
 - review the curriculum plan i.e. study documents.
 - interview the curriculum design team.
 - engage the design team in a deep deliberation to enable the evaluation team to provide feedback. This helps to focus the design team's attention on the educational values they are espousing (orally and in writing)
 - review the aims and intentions of the curriculum and the rationale behind it
 - review the implementation of the curriculum. Here the emphasis will be on teaching sessions, activities of the learners and committees that meet to discuss curriculum's activities. The evaluation team in some way need to make sense of all this. This will be achieved through observation.
 - review what is experienced in the field. The essence is that experiences differ and it may be that what planners consider ought to be happening may well differ from what is actually happening.
 - conduct surveys using questionnaires administered to all relevant stakeholders to solicit their views on the effectiveness of the programme to learners, teachers, managers, policy makers and the public in general.

6. Resources such as transport (vehicle and fuel), logistics (computer, printer, stapler and pins, binding machine) stationery (A4 Sheets, pens) and any other resource (relevant to the evaluation process) that would be required by the evaluation team will be made available.

A programme of educational research and inquiry for the curriculum

7. A programme of educational research in relation to the curriculum will be developed in collaboration with key stakeholders. The research will assist the development of the programme as a whole and the curriculum in particular through providing evidence of efficiency, effectiveness and cost-effectiveness. This will include factors contributing to success and identifying barriers that need to be overcome to support greater positive impact. Evidence from short and intermediate outcome measures will be gathered and used to develop the curriculum on an ongoing basis, contributing to its development over time.
8. Both quantitative and qualitative methods will be used as most appropriate to the particular questions to be answered by the research. Grounded theory and inductive-deductive approaches will ensure that questions important to key stakeholders are addressed in a meaningful way that will provide useful, practical knowledge to ensure evidence-based curriculum development.
9. The detailed programme of research and development will be presented in a separate document currently being written in collaboration with key stakeholders to ensure its meaningfulness and usefulness.

Appendix K

The Process by which this Curriculum was Produced

1. This curriculum was produced over the period 2008 – 2010. The process was detailed and included many meetings and consultation, particularly with practising clinicians and teachers from many fields of mental health and general health practice. Those consulted have included:
 - The Honourable Minister of Health, and Directors of The Ministry of Health
 - The Director General, Ghana Health Service and Directors of GHS
 - Dr Akwasi Osei, Chief Psychiatrist
 - Reverend Professor Fr J Appiah-Poku, Head of School of Behavioural Sciences, KNUST
 - Mrs Amina Bukari, National CPN Coordinator
 - Principals of Nurse Training Schools
 - BasicNeeds, Ghana
 - Ghana Mental Health Educators in the Diaspora
 - Dr Victor Doku, Psychiatrist, Ghana Lead for Mental Health and Poverty Project
 - Traditional Practitioners
 - Police Service
2. The group that developed the curriculum included representatives from:
 - Kintampo Rural Health Training School (KRHTS) - Ghana
 - Hampshire Partnership NHS Foundation Trust (Project Team) - United Kingdom
 - University of Winchester – United Kingdom
3. The document was written by :
 - Dr. E. T. Adjase, Director – KRHTS
 - Mr. Emmanuel Okyere, Curriculum Head, Community Mental Health Officer – KRHTS
 - Mr. Emmanuel Ofori, Curriculum Head, Medical Assistant Psychiatry – KRHTS
 - Mr. N. A. Ashitey, Deputy Director Academic – KRHTS
 - Dr. M. Roberts, Consultant Forensic Psychiatrist - HPFT
4. The following UK practitioners provided educational and clinical advice:
 - Dr. Obed Bekoe – Hampshire Partnership NHS Foundation Trust
 - Professor Colin Coles – University of Winchester, UK
 - Ms. Sally Gore – Hampshire Partnership NHS Foundation Trust
 - Dr. Gwyn Grout – Hampshire Partnership NHS Foundation Trust
 - Dr. Rosie Lusznat – Hampshire Partnership NHS Foundation Trust
 - Dr Anita McBride – Hampshire Partnership NHS Foundation Trust
 - Mr. Daniel Okyere – Hampshire Partnership NHS Foundation Trust
 - Dr. Mark Roberts – Hampshire Partnership NHS Foundation Trust

5. Documents consulted included:

- Ministry of Health Programme of Work
- The Mental Health Law of Ghana
- Ghana Mental Health & Poverty Project (MHaPP) Country Report, June 2008
- Lancet Global Mental Health Series
- Medical Education: Developing a curriculum for practice – Fish and Coles, 2005
- Kwame Nkrumah University of Science and Technology, MB ChB, Degree in Medicine
- Curriculum Framework for the Surgical Care Practitioner – Department of Health, UK, April 2006
- Competence and Curriculum Framework for the Physician Assistant, Department of Health, UK, September 2006
- Physician Assistant in Psychiatry, American Academy of Physician Assistants, December 2006
- European curriculum for training in adult respiratory Medicine – 2nd Report of the HERMES Task Force.
- The curriculum for training mental health nurses – Ghana
- The curriculum for training registered general nurses - Ghana
- The curriculum for training Psychiatry Clinical Officer (PCO) – Uganda
- The curriculum for training Psychiatry Clinical Officer – Tanzania
- The curriculum for training Clinical Officer Psychiatry (Direct Entry) Zambia
- All relevant KRHTS curricula
- PLoS 2009 series on “2 Packages of Care” for mental health disorders in low and middle income countries
- Mullan F, Frehywot S. Non-physician clinicians in 47 sub-Saharan African countries. *Lancet* 2007; published online June 14. DOI:10.1016/S0140-6736(07)60785-5.
- Mid-level cadres as substitutes for internationally mobile health professionals in Africa. A desk review. *Dovlo. D. Human Resources for Health* 2004, 2:7 doi:10.1186/1478-4491-2-7
- The effectiveness of mental health services in primary care: the view from the developing world. Alex Cohen, WHO, 2001.

Appendix L

Definition of Terms Used in the Document

| Term | Definition |
|--|---|
| Audit | A management method for measuring performance against expected standards. |
| Curriculum | A curriculum is an attempt to communicate the essential principles and features of an educational proposal in such a form that it is open to critical scrutiny and capable of effective translation into practice (<i>Stenhouse L 1975:4 An introduction of curriculum research and development</i>). |
| Curriculum document | A document which contains a curriculum statement and includes the rationale for and purpose of the curriculum, and a statement of the curriculum's content, assessments etcetera, together with other related information concerning the management of the educational programme. |
| Drug | An illegal substance such as cannabis, amphetamine etc. This could also include, for example diazepam bought on the open market without any recommendation from a mental health practitioner. The only time drug is used instead of medicine is the title of an official document eg 'National Drugs Formulary'. |
| Medicine | In everyday speech we often refer to 'drugs', e.g. psychotropic drugs, but sometimes this can cause confusion with illicit 'drugs', so in this curriculum we use the word medicine rather than drug. However, the term medicine does not extend to traditional medications, unless specifically stated (eg '...the study of traditional practitioners and traditional medicines..."). |
| Mental disorder, mental illness, mental health | Please refer to textbooks for definitions. The definitions can be lengthy and vary from one place to another. The textbooks for this curriculum are the Oxford Textbooks of Psychiatry. Classification of mental disorders in Ghana uses ICD 10 (this is agreed by the Chief Psychiatrist). For this curriculum mental disorder also includes epilepsy. |
| Pathway | A patient's 'journey' to care (e.g., a 'journey'/ pathway to a psychiatrist could be - consult a friend, go to a traditional practitioner, go to a Medical Assistant in local hospital, go to MAP, go to Psychiatrist). |
| Placement | Where a student gains practise-based experience. |
| Preceptor | Clinician who supervises students on a placement (clinical visits and attachments). Please see the separate preceptors' manual for more information. |

table continues...

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| Professional practice | The intentions and actions through professional means of someone committed to attending to the good of another person. It involves judgement in order to deal with the complexity, uncertainty, and unpredictability of the situations that characterise professional practice. Health care and education are both examples of professional practice, and have much in common. |
| Syllabus | The content of a curriculum. |
| Tutor | Degree holding educator based at KRHTS. |



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