ZIMBABWE NATIONAL MENTAL HEALTH POLICY

ZIMBABWE

MINISTRY OF HEALTH AND CHILD WELFARE

ACKNOWLEDGEMENTS

Many organisations have been involved in the development of Zimbabwe National Mental Health Policy. The Ministry of Health and Child Welfare recognises their contribution and enthusiasm and offer sincere appreciation to the officers from University of Zimbabwe, Department of Psychiatry and Department of Nursing Science, Zimbabwe National Association for Mental Health, Ministry of Justice Legal and Parliamentary Affairs including Prison Services, Zimbabwe Republic Police (Medical Services), Amani Trust, The Madzimai Pabasa Trust, The School of Social Work, Department of Social Welfare, Harare City Health Department, The World Health Organisation, Tariro Centre, ZINATHA, Musasa Project, Zimrights, Ministry of Health and Child Welfare, past and present National Mental Health Co-ordinators.

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FOREWORD

The Zimbabwe National Mental Health Policy is a successor of the Zimbabwe National Mental Health Plan of Action. The Zimbabwe National Mental Health Plan of Action culminated from an inter-sectoral, inter country workshop in September 1984, it became the policy framework within which Mental Health and Psychiatric Services were planned, implemented, monitored and evaluated. It gave high priority to activities designed to inform and mobilise the nation in support and promotion of mental health. It outlined the activities which are necessary for training and development of mental health infrastructure.

The current policy document is a result of hard work and extensive consultation over several years, with stakeholders in health. Its major aim is to harmonise mental health activities and to improve the quality of care of those living with mental disorders. It calls for a great need for the public and private sectors to pull together to improve the quality of life of all those living with mental disorders, and increased community involvement and participation. It will provide a framework within which mental health programmes, projects and activities can be designed, implemented, monitored and evaluated, using the multi-disciplinary, multi-sectoral approaches, community involvement and participation, within the context of Primary Health Care to provide all Zimbabweans with the highest achievable mental health care services.

Signed:

SECRETARY OF HEALTH AND CHILD WELFARE

ACRONYMS AND ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
DALY	-	Disability Adjusted Life Years
EDLIZ	-	Essential Drug List of Zimbabwe
GBD	-	Global Burden of Disease
GOZ	-	Government of Zimbabwe
HIV	-	Human Immuno Deficiency Virus
MHA	-	Mental Health Act
NGO	-	Non Governmental Organisation
QALY	-	Quality Adjusted Life Years
RHC	-	Rural Health Centre
S.I	-	Statutory Instrument
WHO	-	World Health Organisation

DEFINITION OF TERMS AND CONCEPTS

Act	is the Mental Health Act. (Chapter 15:06)
Community involvement	is the process by which individuals, families and various groups take part in diverse activities.
Community participation	is a process by which individuals, families and various groups assume responsibility for their own health and welfare and for those of the community and develop the capacity to contribute to their own mental and that of the community.
Custodial care	care that is more like punishment or imprisonment with little or not contact with the community and with very limited amount of or no rehabilitation at all.
Decentralisation	the downward disbursement of responsibility and functions with the various levels of care
Deinstitutionalistion	a humanitarian philosophy committed to community based care for the mentally ill clients resulting in the emergence of community based treatment and rehabilitation facilities and the reduction of patients in mental health hospitals/institutions.
Discrimination	any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights.
Exploitation	the act of using persons unfairly, selfishly and taking advantage of them.
Informed Consent	consent that is obtained freely without threats or improper inducements after appropriate disclosure to the patient or significant other, of adequate and understandable information, in a form and language understood by the patient or the person or family member responsible for the patient.
Integration	the combination of mental health services with general health services.

Marginalisation	the act of making a group of people unimportant and powerless.
Ministry	unless otherwise specified, Ministry in this document refers to the Ministry of Health and Child Welfare.
Multi-disciplinary	an approach actively involving different disciplines (e.g. nursing, psychology, social work, rehabilitation, health education etc)
Muti-sectoral	an approach that actively involves different sectors (e.g. Health, Justice, Home Affairs, Prisons, NGOs etc)
Private Sector	includes private for profit and private for non profit organisations (NGOs)
Prejudice	preconceived bias which influences against another person.
Psychiatric Nurse Practitioner	is a Registered General Nurse with a post basic Diploma or Degree in Psychiatric and Mental Health Nursing, a vast experience in Psychiatry and who has successfully completed his/her Masters Degree in Nursing Science, majoring in Mental Health and Psychiatric Nursing, and who has undergone a three months internship and registered with the Health Professions Council.
Public Sector	all government institutions.
Regulation	The Mental Health Regulation Statutory Instrument 62 of 1999.
Sexual Abuse	unwanted, unlawful, immoral and/or unwanted sexual contact of any degree.
Special institution	are special psychiatric units within hospitals which are either run by or supervised by registered psychiatrists.
Stigmatisation	making one shameful and disgraceful.
Support groups	a group of people who share a similar problem, who come together to provide each other with psychological, emotional, social, spiritual, informational, moral, material and other forms of support.

Unit	a section in a hospital which is composed of two or more wards, offices, administrative offices and various other departments such as the rehabilitation and occupational departments.
Ward	a room in a hospital where mentally ill patients stay for treatment and care.

ZIMBABWE NATIONAL MENTAL HEALTH POLICY

1. MISSION STATEMENT OF THE MINISTRY OF HEALTH AND CHILD WELFARE.

To provide for all Zimbabweans, a comprehensive, co-ordinated, quality mental health service that is integrated into the general medical health system with the aim of improving the mental health of the nation.

2. INTRODUCTION.

Mental health is an essential and integral part of health. Mental health is defined as a state of mental well being in which the individual realizes his or her abilities, where one can work productively and fruitfully and be able to contribute to his/her own community and not simply the absence of detectable mental disorder (WHO, 1996). It is unfortunate that the term "mental health" is often mistaken in society to mean mental disorder.

Mental disorder is defined as the maladaptive response to stressors from the internal or external environment, evidenced by thoughts, feelings and behaviours that are incongruent with local and cultural norms, and interfere with the individual's social occupational, and/or physical functioning (Townsend, 1996).

The burden of mental disorder, such as depression, alcohol dependence and schizophrenia has been seriously underestimated by traditional methods of measuring the health status of the population, because of, generally, their non-fatal nature. The Global Burden of Disease (GBD) is a method of quantifying the health status of a nation which measures not merely the number of deaths, but also the impact of disability of a population. Some of the tools used in GBD are the Quality Adjusted Life Year (QALY) and the Disability Adjusted Life Years (DALY). Using the QALY, mental health problems rank highly among the largest causes of lost years of quality of life. Using the DALY, of the ten leading causes of disability world – wide in 1990, five were psychiatric conditions: unipolar depression, alcohol abuse, bipolar effective disorder (manic-depression), schizophrenia and obsessive compulsive disorder. Unipolar depression alone was responsible for more than one in every ten years of DALY (1%) of deaths, this accounts for twenty-six per cent (26%) of years lived with disability, and eleven per cent (11%) of the disease burden world-wide (WHO & The World Bank, 1996). It is further projected by WHO that by the year 2020 Depression alone could be the leading cause of disability world wide. Currently it is estimated that more than 300 million people globally suffer from depression, with another 45 million suffering from schizophrenia. These figures continue to grow at an alarming rate globally.

Some of the reasons leading to an increase in mental health problems are the harsh economic situation, unemployment, poverty, conflicts, change in the disease pattern, particularly the HIVand AIDS pandemic. There are a large number of children who are brought up as orphans, leading to an increase in psychological disorders, and the manifestation of mental disorders much earlier in life. This also leads to drug and

alcohol abuse. Post war effects on individuals, families and the community had led to a large number of persons suffering from Post Traumatic Stress Disorder.

This policy would assist in giving comprehensive, integrated quality mental health services, despite the shortage of human and material resources through multi-sectoral and multi-disciplinary approaches, community involvement and participation and strengthening of the integration of mental services into the general health services.

The broader part of the field of mental health encompasses the promotion of mental health, the prevention, treatment and rehabilitation of mental disorders. The Zimbabwe Government among its priorities since independence (1980) has included the promotion of mental health, Promotion of mental health and the prevention of mental disorders continue to remain a challenge. Some of the challenges faced are: -

- Limited human resources
- Limited material resources
- Limited collaboration between the public and private sectors
- Limited dissemination and utilization of research findings
- Stigma attached to mental illness
- Negative attitudes related to mental illness
- Limited rehabilitation services
- The HIVand AIDS pandemic and its mental health implications

2.1 Limited Human and Material Resources

Although Zimbabwe trains its own Psychiatric Nurses, Clinical Psychologists, Clinical Social Workers and Psychiatrists, there is still a critical shortage of all these cadres. There is not only a need to increase the numbers trained but also to provide incentives to reduce the rate of brain drain through loss to other neighbouring countries and abroad. While the need to train mental health professionals is clearly crucial , empowering existing general medical professionals with relevant mental health skills is equally crucial if true integration is to be achieved.

- **At primary level**. To improve the quality of care, there is need to aim at having at least one trained psychiatric nurse per Rural Health Centre or clinic. This is to provide for:
    - the early identification of the mentally ill and mentally retarded; as well as
    - carrying out the initial assessment;
    - support of the patient and relatives;
    - support of the other clinic staff members, the Village Health Worker and other extension health workers.

  The Psychiatric Nurse would also initiate and monitor rehabilitation programmes, follow up of patients and referral as necessary.

- **At district level**, the psychiatric nurse can:
  - advise doctors; general nurses and midwives on the care and management of the mentally ill patients;
  - facilitate the provision of short-term inpatient care of the mentally ill;
  - screening and referral to the next level as necessary;
  - running out-patients clinics;
  - support of staff at lower level;
  - education of the community and fellow staff; as well as
  - co-ordinating all the mental health activities of the district.

- **At provincial level**, the senior psychiatric nurse can:
  - advise and support the doctors, general nurses, midwives and other junior psychiatric nurses at both district and provincial levels; as well as
  - co-ordinate all the mental health activities of the province.

  The Psychiatric Nurse Practitioner at provincial level would:
  - assist with the assessment of mentally disordered offenders; as well as
  - the after care of the mentally disordered offenders;
  - the filling in of medical recommendation forms for patients needing referral to upper levels of care; and
  - providing expert advice for the courts as necessary.

  At Central Hospitals and Mental Health Institutions, specialised care would be made available.

2.2 Limited Collaboration Between the Public and Private Sectors

The relationship between Government and the private sector has been adversarial and marked by mutual mistrust. Closer collaboration is required to overcome the long-standing biases and negative attitudes between the two. This can only be achieved through greater openness and trust. As a recent World Bank Health Policy document states, neither sector is effective in itself, each needs the other. Both too much and too little involvement by either sector is often associated with problems. Expanding the role of the private sector, together with targeting of limited public funds to those in most need, can help increase overall access to mental health care. By encouraging the wealthier clients to use unsubsidised sources of care, government can more easily focus their own funds on the poorest, vulnerable and disadvantaged members of society and the most remote communities. However , public mental health facilities could still be utilized for private patients (paying patients), particularly in the treatment of substance abuse related conditions which are highly prevalent in the country. Currently most Zimbabweans needing these services have to travel to neighbouring countries. There is a need to increase public awareness on issues related to substance abuse particularly alcohol and reinforce treatment of these conditions in public health facilities.

2.3 Limited Dissemination and Utilization of Research Findings

Besides studies done in other countries, various mental health related researches have been carried out in Zimbabwe, mainly by health professionals undertaking various

Master's Programmes. Unfortunately, the dissemination of this information has been very poor. Much work is required to strengthen this area. The ministry of health could play a pivotal role by providing technical support for research in mental health. The ministry of health can put in place a national mental health data base providing vital information on mental health issues.

2.4 Stigma attached to Mental Health and Negative Attitudes Related to Mental Illness

Mental disorder is a condition that continues to generate fear, prejudice, misunderstanding, misinformation, marginalisation and discrimination. The mentally disordered are sometimes:

- shunned and isolated;
- neglected and/or avoided;
- forced out of their jobs or homes;
- denied or stripped of their human and civic rights;
- exploited and subjected to indignity and intolerance.

Negative attitudes, beliefs and values or misinformation about mental illness significantly affect the ability to provide efficient, effective, respectful, dignified care and support for those living with mental illness, as well as supporting their families.

People labelled as "psychiatric patients" acquire a discredited social identity because of character flaws often associated with the label. This stigmatisation has been evident for centuries. Historically the treatment of psychiatric patients has been brutal, inhumane and custodial in nature. The era of deinstitutionalisation began in early 1960s, with a call for the humane treatment of the mentally ill. In Zimbabwe the practice of psychiatric mental health workers should continue to rise to the occasion by stamping out the stigma attached to mental illness and continue to advocate for the humane treatment of patients. Mental health legislation can play a pivotal role in addressing human rights issues in mental health by using human rights as the framework for mental health law in the country.

2.5 Limited Rehabilitation Services

In Zimbabwe, comprehensive rehabilitation facilities for the mentally ill are very scarce. There is need for each province to come up with a comprehensive rehabilitation programmes utilizing available facilities and resources. This would allow for the adequate rehabilitation of the mentally ill and thus promoting self-autonomy and independence, self-sufficiency and productivity. Examples of such rehabilitation schemes in Masvingo Province should be emulated and replicated throughout the country. In addition, diverse rehabilitation programmes should be developed and maintained countrywide. The limited available resources should generally be focused towards community based services, thus the concept of decentralization should be promoted.

2.6 The HIV and AIDS pandemic and its mental health implications

The HIV and AIDS scourge remains the greatest challenge to the country's health delivery system . The complex multi-dimensional facets of this pandemic demands a holistic approach to its management. By including a mental health component to the National HIVand AIDS Programme, issues related to prevention, counselling, psychosocial support and the management of HIV related psychiatric conditions will be co-ordinated at all levels to produce a more coherent HIV and AIDS programme. With the recently announced '3 BY 5' initiative with WHO the need for a mental health component in the National HIV and AIDS Programme is crucial.

3. BACKGROUND INFORMATION

At independence in 1980, the Government of Zimbabwe adopted the Primary Health Care concept, which requires mental health services to be decentralized and integrated into general health care system. As a result, mental health services continue to be made socially acceptable, accessible, and affordable with a community focus which enables the community to get involved and participate fully.

The decentralization and integration of mental health services (horizontal programme) in general health care led to the introduction of a component of mental health in all basic and post basic curricula, the on-going in-service training and on-going supervision and support of general nurses. Medical students also have a mental health component in their training programme.

Some of the major achievements of the mental health programmes have been through advocacy. Some of the major achievements of the advocacy are: -

3.1 The passing of the Mental Health Act in 1996 and the Mental Health Regulations of 1999 and their implementation in the year 2000.

3.2 The construction of the two provincial psychiatric units and one district psychiatric ward.

3.3 The setting aside of wards to function as provincial psychiatric units and wards in already existing facilities at two provincial hospitals.

3.4 The inter-country, inter-sectoral Mental Health Workshop held in Harare in September 1984, which produced the Zimbabwe Mental Health Plan of Action which has bee extensively used to guide Mental Health Services.

4. OBJECTIVES OF THE ZIMBABWE MENTAL HEALTH POLICY

The objective of the Zimbabwe Mental Health Policy is to provide a framework within which mental health programmes, projects and activities can be designed and implemented, monitored and evaluated using multi-disciplinary and multi-sectoral approach within the context of Primary Health Care.

5. GUIDING PRINCIPLES

The following are the guiding principles of this policy: -

5.1. **Mental Health is a fundamental human right** and all persons irrespective of sex, gender, age, race, ethnic origin, tribe or creed have the equal right without any discrimination to the highest attainable mental health care which is to be part of the general health care system at all levels of the health delivery system.

5.2. **In the face of the HIV and AIDS scourge** mental health issues will be given the priority they deserve in an effort to address the complex facets of this pandemic.

5.3. **There is a recognition of the vulnerability of certain groups within society** such as women and children (but not limited to) whose special needs must be met.

5.4 **Decentralised mental health care services is the cornerstone** of sustainability. Decentralisation will increase access to mental health services, particularly in the rural areas where mental health facilities are inadequate.

5.5 **Mental health services should be integrated at all levels** as far as possible with general services.

5.6 **Both in and out patient care** should be available at all levels of care and should be equitable to general health services.

5.7 **Rehabilitation services to be made available** at all levels of care and should include a discharge plan.

5.8 **Specialised rehabilitation services** should include:

- day care centres;
- halfway homes;
- hostels;
- resettlement schemes; and
- vocational training centres.

All of these services should be improved, strengthened and increased in the communities.

5.9 **The delivery of mental health care must be firmly established** by utilising the multi-sectoral and multi-disciplinary approaches in order to meet the demands of the population as a whole for a comprehensive coverage of mental health care services.

5.10 **Public and private sector to work closely together.** The public and private sectors have a social responsibility for providing mental health services through alliance building, networking and by working in partnership.

5.11 **Community involvement, information dissemination and participation** is paramount in the success of mental health care delivery.

5.12 **Professional standards and ethics** should guide practice.

5.13 **The right to confidentiality** of information regarding the patient shall be respected.

5.14 **All persons with a mental disorder have a right to protection from:**
- sexual and other forms of exploitation;
- discrimination;
- marginalisation;
- stigmatisation;
- physical or other forms of abuse; and
- degrading treatment.

5.15 **The informed consent of the patient, guardian or responsible person must be obtained** for therapeutic procedures to be undertaken. Where such consent is not possible, the Mental Hospital Board in terms of the Regulations for the institution has authority to grant such consent after the Board has satisfied itself that the treatment, and procedure best serves the health needs of the patient, and that the research will not cause any harm to the patient (Section 50 of the Act).

5.16 **All research involving persons with mental illness** should be subject to the same review procedures and requirements as dictated by the local institutional review board as defined in the Act

5.17 **A patient shall have the right** should their treatment take place in a mental health facility, whenever possible:
- to be treated near his or her home; or
- the home of his or her relatives or friends if preferable; and shall
- return to his/her community as soon as possible.

5.18 **Physical restraints or involuntary seclusion of a patient shall not be employed** except in accordance with section 24 of the Regulations, and sections 113 and 114 of the Act.

5.19 **Should a person require treatment in a mental health facility,** every effort shall be made to avoid involuntary admission.

5.20 **Access to a mental health facility** shall be administered in the same way as access to any other health facility for any other illness.

5.21 **These guiding principles shall apply to criminal offenders** to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances.

6 ADMINISTRATION AND STAFFING

For the effective and efficient administration of mental health services, the Government of Zimbabwe shall put in place: -

6.1 **At national level**, there will be a mental health unit within the Ministry of Health and Child Welfare. This unit is to be headed by a Deputy Director National Mental Health Services who will report directly to the Director of Technical Services.

There will be a supporting team of:

- A clinical psychologist;
- A psychiatrist
- family therapist;
- social worker;
- counsellor;
- occupational Therapist; and
- Rehabilitation Technician.
- The support team does not have to be based at head office, however, will have to liaise regularly with the mental health director.

6.2 **At provincial level,** the mental health team who will be headed by a Provincial Mental Health Co-ordinator who is an appropriately trained mental health practitioner in accordance to the regulations governing the Medical Health Professions Council of Zimbabwe, will be responsible for all the mental health activities that are to be carried out in that particular province.

6.3 **At district level,** the mental health team will be headed by a District Mental Health Co-ordinator who is an appropriately trained mental health practitioner in accordance to the regulations governing the Medical Health Professions Council of Zimbabwe. The District Mental Health Co-ordinator will be responsible for all the mental health activities that are carried out in the particular district.

6.4 **At community level,** the Nurse-in-Charge of the Rural Health Centre or Clinic will head the team comprising of extension workers, and will work in partnership with the community to promote mental health

6.5 **In addition to Medical Practitioners,** officers such as Psychiatric Nurses. Social Workers, and Clinical Psychologists shall be designated in terms of Section 108 of the Act, to provide specialised services as outlined in this Act.

6.6. **Provision of separate facilities for children with mental disorders,** in line with section 22 (g) of the Regulations. This can be realized by having Child

The Government of Zimbabwe shall make provisions for:

12.8 **Discretional powers** for arresting officers, magistrates and prosecutors to accommodate those with mental disorders who commit minor offences to be accommodated in civil institutions.

12.9 **The improvement of the rehabilitation facilities** within the special institutions.

13. TREATMENT AND REHABILITATION

The Government of Zimbabwe has a role in ensuring that those persons requiring mental health services and who cannot afford care at market prices, can obtain essential mental health care, products and services free of charge. Therefore the Government of Zimbabwe shall make provision for: -

13.1 **Free promotive** and preventive mental health services.

13.2 **Curative and rehabilitative mental health services** free of charge unless proof is available that patient has the means to be able to pay for the services in whole or in part.

13.3 **Psychotropic, psychotherapy, counselling, behaviour therapy, psychosocial treatment and rehabilitation therapies** to be made available in all mental health facilities for the treatment and rehabilitation of those persons with psychiatric disorders.

13.4 **The care of every patient to be based on their individual needs** as agreed with their guardian, family member or other responsible person as the case may be. Should the patent's mental status be such that his or her treatment can be discussed with him or her or as soon as the patient's mental status permits, the prescribed plan should also be discussed with the patient.

13.5 **The administration of medication that best meets the health needs of the patient** to be given for therapeutic and diagnostic purposes and never as a form of punishment or for the convenience of others. This medication shall be of known or demonstrated efficacy.

13.6 **The provision of essential drugs** to be in line with the EDLIZ 2000 (or the current version of EDLIZ), Drug Policy of Zimbabwe, and the Medical Services Bill

13.7 **The current recognised EDLIZ version** should be used to guide prescription in line with the Drugs and Allied Substances Control Act, (Chapter 15:03), the Medical Services Bill and the Health Professions Council of Zimbabwe.

13.8 **Basic drugs at RHC level** (refer to EDLIZ 2000 or the most recent version of EDLIZ). To be reviewed in order to include a wider range of psychotropic medications.

13.9 **The encouragement of rational drug use.**

13.10 **Adoption of good drug ordering and storage practices.**

13.11 **Encouragement of a community driven psychiatric service,** to support patients and their families in their communities, as a continuum of care.

14. CO-ORDINATION, COLLABORATION AND CO-OPERATION

The Zimbabwe Government shall develop a multi-disciplinary and multi-sectoral approach to the delivery of mental health services at all levels with an emphasis on decentralization and community participation.

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