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communities; some centres have long-term residential care. However, there are primary psychiatric services in health centres and health posts, usually run by a CPN with support from a district or regional hospital.

Patients with serious psychiatric illness are normally transferred to the psychiatric hospitals, two in Accra and one in Cape Coast. The hospitals also provide teaching and research facilities to the medical schools. There are no special services for old age psychiatry, forensic psychiatry and child psychiatry; while a couple of private establishments provide rehabilitation and training for learning disability. Admission to the hospital is free to all patients; medication and tests are subsidised but free to those declared as paupers. Two university psychiatric departments in Accra and Kumasi also offer out-patient clinical services, in addition to teaching and research work. The departments' staff establishment numbers are low and have no adequate premises.

## Present workforce

There is the perennial problem of inadequate staffing. Psychiatrists, nurses, clinical psychologists, occupational therapists, social workers and CPNs are hard to come by. In two of the hospitals there are fewer or no paramedical staff and until very recently one hospital had no psychiatrist in post for many years. There are presently only 12 psychiatrists practising in the country. One has recently retired, four are employed by the medical school, three work in private practice and the rest with the Ministry of Health. Thus, in all, there is one psychiatrist per 1.5 million people. This unrealistic work-load has serious implications for patient care and job satisfaction.

## Suggestions for improved services

Since the 19th century great strides have been made in the development of psychiatric services in Ghana from its humble origins in 1886. However, a lot more needs to be done if the standard of psychiatric care is to be raised to the level commensurate with recent advances. This would require massive investments in infrastructure and not least in trained personnel.

The Government's policy of expanding psychiatric services to district and regional hospitals ought to be commended. This includes extension of services for primary psychiatric care in remote areas owing to the present skewed distribution of facilities, where patients have to travel hundreds of miles for treatment. Establishing an accelerated training programme for all levels of personnel, including psychiatrists, locally (not compromising on internationally accredited standards of teaching and care) should provide a regular stream of staff to man the hospitals and health centres. Adequate remuneration of staff should help to solve the long-term problem of 'brain drain' and, indeed, encourage personnel trained overseas to return home.

More than 100 years ago the fundamental human right to have access to care and especially legal rights for those suffering from mental illness, were probably not recognised in the Gold Coast, as in many other countries. Since then the rights of those suffering from mental illness have been propagated by the World Health Organization and should not only be enshrined in legislation, but also be seen to be practised by all professionals involved in the care of those suffering from mental illness.

Public education to overcome widely held traditional myths about mental illness, which are still fairly prevalent in the society, would help to encourage more patients and relatives to seek early professional treatment than was the case over 100 years ago.

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# Workshops at annual general meetings

Workshops at the College's Edinburgh Annual General Meeting (AGM) in July proved to be very popular, attested by the fact that nearly 1000 delegates attended 27 of them, which were distributed over the 5 days of the conference. The College has only recently introduced this format into their AGMs, although faculties and sections have long been including them into their residential meetings, again with positive feedback from those attending. As a result, the Edinburgh Organising Committee asked me to take on the job of Workshop Director for the conference, for which I had no real track record, although I had been previously involved in organising conferences and workshops for the Rehabilitation and Social Sections.

The experience for workshop facilitators in Edinburgh had been a fruitful one, and with this in mind I devised a feedback form to try and collate what had been learnt. I was interested to find out that a large proportion had run workshops many times before, although most had learnt on the job. Some reported the desire for



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training in workshop methods, or a set of workshop guidelines. With this in mind, I have collated their responses, and prepared a 10-point set of workshop guidelines that hopefully readers of the *Bulletin* and future workshop leaders at AGMs can use.

## Ten guidelines for conducting workshops

Workshops are essentially interactive learning opportunities. They offer the potential to bring to the fore current concerns highlighted by the participants, under a specific theme heading. They should be considered as guided opportunities for exploration and sharing of common clinical or research problems and possible arrival at solutions. Participants will be expecting to be encouraged to ventilate their own difficulties, hear similar contributions from other members and leave with a clearer notion of the issues and some ideas as to how to tackle them on return to their own working environment.

There are various models and techniques that can be applied for successful workshops, and the following 10 guidelines have been collated from facilitators at previous conferences, which might be of help when you are planning your exercises.

### One

Workshops need considerable thought and preparation. It is best to consider them as phased learning processes. These phases need to be mapped out in a progressive fashion, with allotted times for introductions, personal statements and expectations, factual presentations of the main topics to be covered, group work and summary conclusions. You should have a clear idea of what you wish to achieve by the end of the workshop. Facilitators should not aim to cover too broad a topic or the whole field: concentrate on two or three practical aims or points. Having a co-facilitator may be of help in the preparation and execution of the workshop, but more than two can be difficult to manage. Think about the maximum number of delegates that can attend, and if breakout discussion groups are planned, how many of these groups can be incorporated in the time available. Plan chair positioning (rows, circle, horseshoe shape) and possible chair movements during the course of the workshop.

### Two

Be prepared for latecomers! Spend a good 5 minutes on individual introductions. Participants should not only state their name and provenance, but also their current work responsibilities and reasons for joining the workshop. If possible, at this stage, they should state what they want to obtain from the workshop. You may wish to have a short warm-up, ice-breaking exercise.

### Three

You may choose to give a short presentation (no longer than 10 minutes) on the subject at hand. This should only basically state or define the problem area to be discussed, set out the geography and the landmarks and even be interactive. Experience shows that facilitators spend too long on the introductory presentation, leaving themselves very little time to invite audience participation. Keep an eye on the clock: remember you will only have 1 and a half hours and it is surprising how time flies! It would be helpful if you have handouts with summaries of your presentation.

### Four

You may suggest an exploratory task, a specific question, a clinical vignette or a common dilemma with the aim of brainstorming and trawling of ideas. Give all participants a chance to state how the problem affects their practice. There may be a need to break the groups down to a smaller number in order to achieve this. The small groups will have to select a rapporteur and a scribe and specific ideas and concepts should be noted down. Try and get maximum participation, inviting those less forthcoming to make contributions. It is important that you clearly state how long the group should meet, and forewarn them that you will let them know when time is running out.

### Five

Remember, you are both a facilitator and the 'skipper'. You do not provide the content of the workshop, but encourage it to emerge from all participants. This does not mean that you have not anticipated what is likely to surface during the course of the exercise. You have to have a reasonable idea where you are heading and what goals you want to achieve.

### Six

Make the groups report back on their conclusions. Ask for responses from the other groups. You may wish to sum up their main findings, set up a priority list of problem areas or simply redefine the problem in other terms.

### Seven

This may lead to a next phase of short presentation, which takes the subject to other areas of complexity. This presentation can end with further subsequent tasks or questions for the groups to work on.

### Eight

Repeat the same format as in guidelines three and five.



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## Nine

In the final section, try and put together the main findings or suggestions emanating from the exercises. Be prepared to be surprised by notions you had not considered. Ask the participants if they feel they have covered the main areas of concern, and also what they are taking away from the experience. What can they apply in their workplace? Is there a commitment to try these new ideas soon? Would they like to report back and give some feedback to the facilitator?

## Ten

It is worth doing a *post hoc* analysis of the workshop. Did the format permit or encourage active participation? Did you work well with your co-facilitator? Were the main topics covered in the time available? Did participants take away someting worthwhile? Could other techniques have been used? This information should be stored to fine-tune your next workshop on the same subject.

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