NEPAL (CHITWAN DISTRICT)

MENTAL HEALTH CARE PLAN

ACRONYMS

AHW: Auxiliary Health Worker
ANM: Auxiliary Nurse Midwife
AUD: Alcohol Use Disorder
AUDIT: Alcohol Use Disorder Identification Tool
BA: Behavior Activation
BDI: Beck Depression Inventory
BEH: Behavior Disorder
CC: Community Counselor
CIDT: Community Informant Case Detection
CPSW: Community Psychosocial Worker
DD: Depression Disorder
DPHO: District Public Health Office
EPL: Epilepsy
FAM-PSY: Family Support for Psychosis
FCHV: Female Community Health Volunteer
GCC: Grand Challenges Canada
HA: Health Assistant
HMIS: Health Management Information System
HNTPO: Health Net TPO
IEC: Information Education and Communication
LMIC: Low and Middle Income Country
LMIS: Logistic Management Information System
MCHW: Maternal and Child Health Worker
MG: Mothers 'Grou
IC: Individual Client

MHCP: Mental Health Care Plan
MI: Motivational Interviewing
PACT-HD: PREMIUM Approach To Counseling Treatment Harmful Drinking
PACT-DD: PREMIUM Approach To Counseling Treatment Depression Disorder
PHC: Primary Health Care Centre
PHI: Public Health In-Charge
PHQ9: Patient Health Questionnaire
PREMIUM: PRogram for Effective Mental Health Interventions in Under-resourced Health Systems
PRIME: PRogramme for Improving Mental health carE
PSY: Psychiatrist
SAHW: Senior Auxiliary Health Worker
SFCI: Stepped Family Care Intervention
SN: Staff Nurse
TEC: Teacher
THP: Thinking Healthy Program
TH: Traditional Healer
TPO: Transcultural Psychosocial Organization Nepal
UCT: University of Cape Town
UOL: University of London
VDC: Village Development Committee
VDCS: Village Development Committee Secretary
VHW: Village Health Worker

NOTE: Government of Nepal has upgraded VHW and MCHW, and named them as AHW and ANM respectively.

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I. Introduction

More than 13% of the global burden of disease is due to mental illness. Although the vast majority of people affected by mental illness live in Low and Middle-Income Countries (LMIC), most mental health care resources are located in High-Income countries. This lack of resources for effective treatment has contributed to a large "treatment gap," with 4 out of every 5 people with mental illness in LMIC going without mental health care.

The PRogramme for Improving Mental health carE (PRIME) is a Research Programme Consortium (RPC) led by the Centre for Public Mental Health at the University of Cape Town (South Africa), and funded by the UK government's Department for International Development (DFID.) PRIME's aim is to develop world-class research evidence on the implementation, and scaling up of treatment programmes for priority mental disorders in primary and maternal health care contexts in low resource settings. It is a six year programme running from 2011-2017, and based in Ethiopia, India, Nepal, South Africa and Uganda. Comparing experiences across these diverse settings, which include fragile settings, will enable PRIME to generate knowledge with local and international relevance.

PRIME aims to improve the coverage of treatment for priority mental disorders by implementing and evaluating the WHO's mental health Gap Action Plan (mhGAP) guidelines. These guidelines are a practical tool designed to empower health care practitioners to deliver mental health services at the primary health care level. PRIME will work closely with Ministries of Health, health care providers, academic institutions and civil society organizations to set up "demonstration sites" in each of the five countries. By generating research evidence aimed at integrating mental health care into primary and maternal health systems, PRIME aims to make a direct contribution to reducing the "treatment gap" not only in the five PRIME countries, but also in other low resource settings.

Partners and collaborators in the consortium include Addis Ababa University and Ministry of Health (Ethiopia), Sangath, Public Health Foundation of India and Madhya Pradesh State Ministry of Health (India), Health Net TPO and Ministry of Health (Nepal), University of Kwazulu-Natal, Human Sciences Research Council, Perinatal Mental Health Project and Department of Health (South Africa), Makerere University and Ministry of Health (Uganda), Basic Needs, Centre for Global Mental Health (London School of Hygiene & Tropical Medicine and Kings Health Partners, UK) and the World Health Organization (WHO). Transcultural Psychosocial Organization (TPO) Nepal is the lead NGO implementing partner in Nepal.

During the first year of the programme, PRIME developed an integrated mental health care plan comprising packages of mental health care for delivery in primary health care and maternal health care. Implementation will take place in years two through four, testing the feasibility, acceptability and impact of the packages of care in primary health care settings.

This document is the District Mental Health Care Plan for PRIME in Nepal. It outlines the care delivery framework, training packages, and details activities in each component of PRIME at different levels: the health organization level (Ministry of Health, District Health Office, District Hospitals, mental health organizations), the health facility level (primary health centers, health posts and sub-health posts), and the community level.

II. Overview

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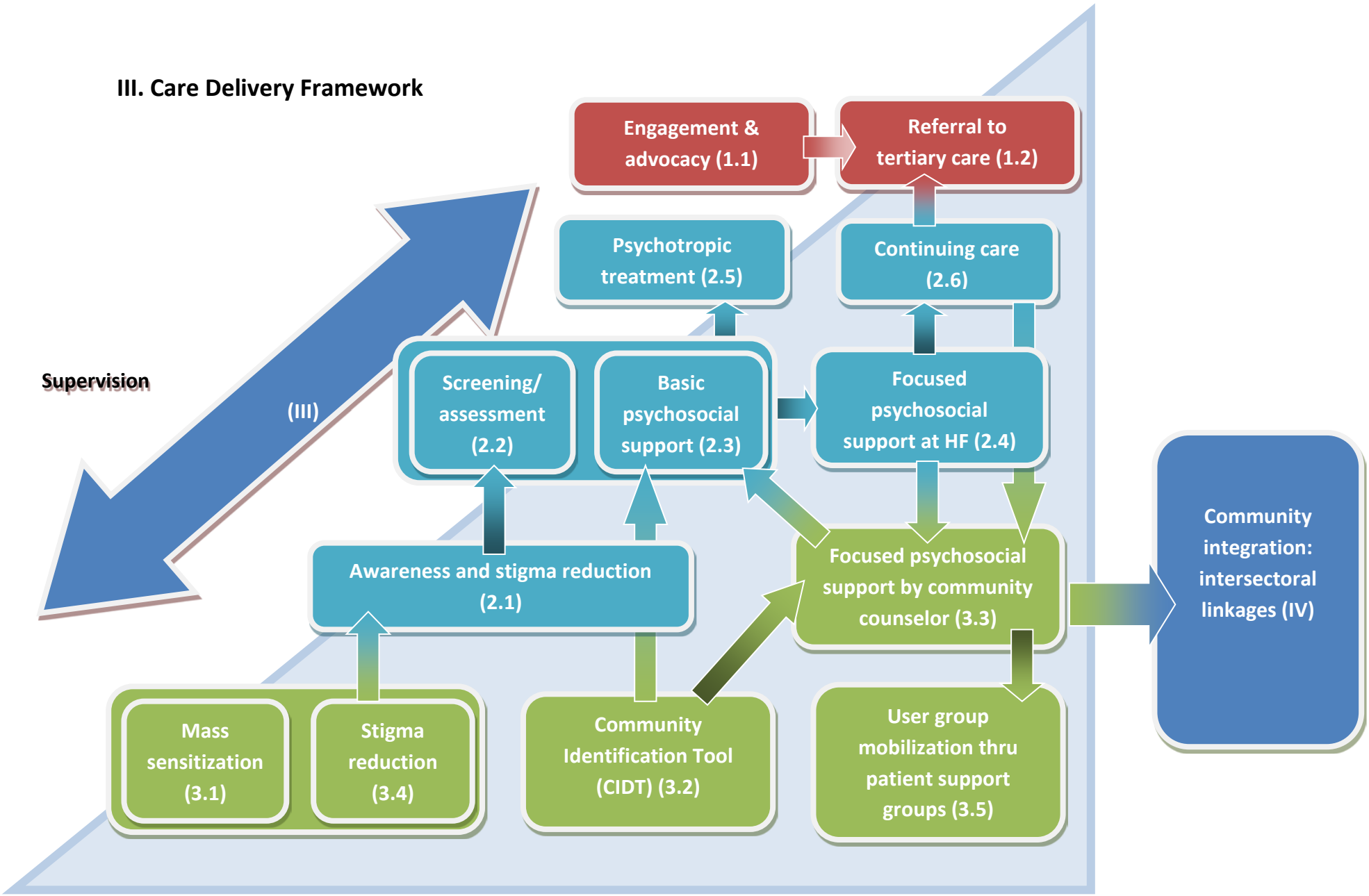
III. Care Delivery Framework



IV. Overview of training: Health facility

Component	Training materials	Days of training	Participants	Trainer
2.1 Service provider awareness	BasicNeeds community mental health workers manual WHO mhGAP training materials	2 days *(level 1)*	All health facility staff	PRIME Intervention Coordinator/ Community Counselor
2.2 Screening and assessment	WHO mhGAP training materials	Part of 5 days mhGAP training *(level 3A)*	Prescriber*	Psychiatrist
2.5 Psychotropic treatment	WHO mhGAP training materials	Part of 5 days mhGAP training *(level 3A)*	Prescriber*	Psychiatrist
2.3 Basic psychosocial support	TPO Nepal CPSW manual	2 days training*(level 2)*	All health facility staff	TPO Counselor/ Community Counselor
2.4 Focused psychosocial support	Adapted PREMIUM manuals Motivational Interviewing (PACT-HD) (brief) Adapted PREMIUM manuals for Behavior Activation (PACT-DD) (brief) THP manual for maternal depression	MI *(level 3B)* BA *(level 3B)*	Non-Prescriber*	TPO Trainer/ Community Counselor
2.6 Continuing care	WHO mhGAP training materials	Part of 5 days mhGAP training *(level 3A)*	Prescriber*	Psychiatrist

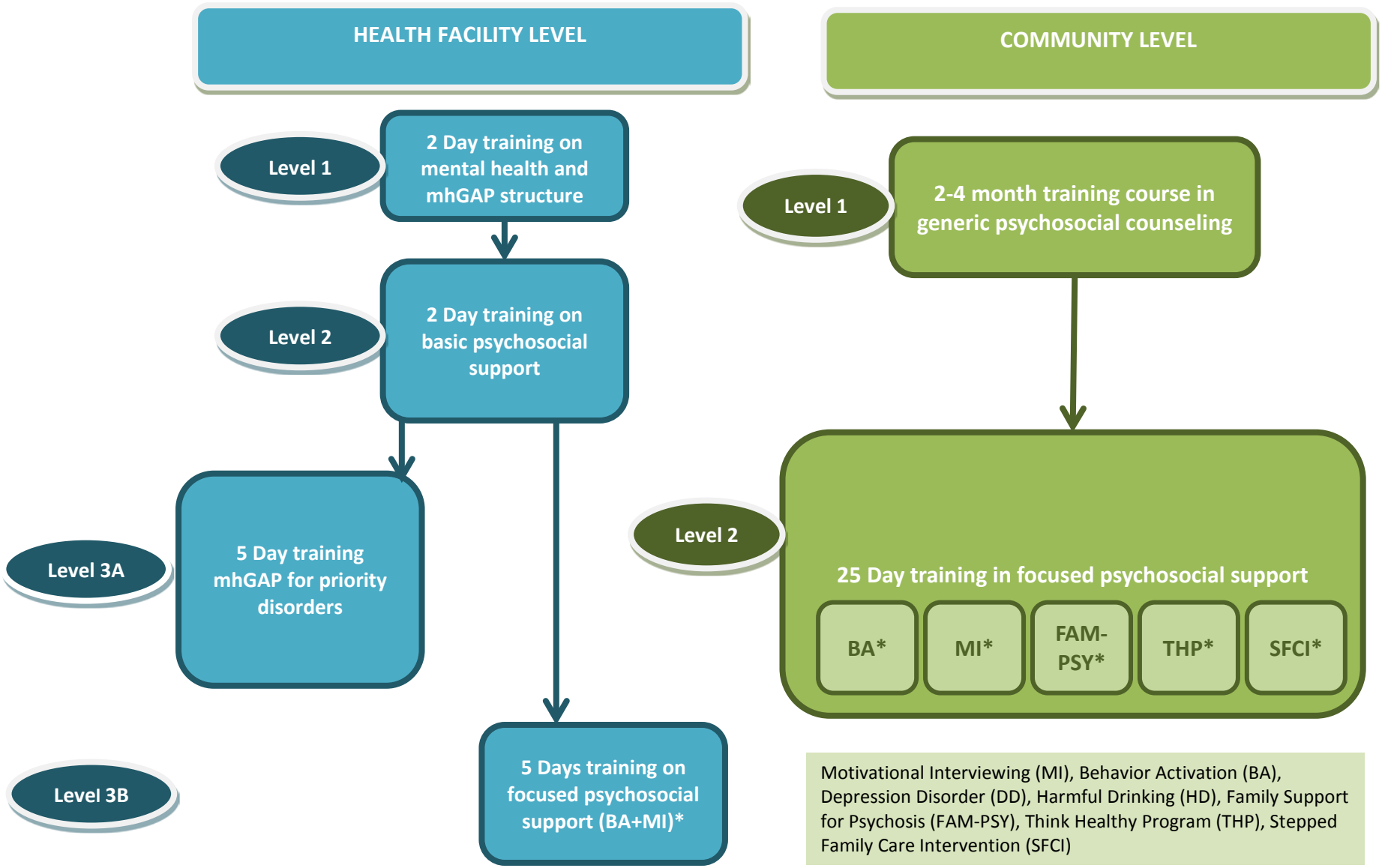
*Prescribers: Medical officer, Public Health in charge, Health Assistant, Auxiliary health worker
*Non-prescribers: Auxiliary nurse mid wife, Village Health Worker, Maternal and child health worker

V. Overview of training: Community

Component	Training materials	Days of training	Participants	Trainer
3.1 Community sensitization	IEC materials of UCT GCC Stigma Reduction Package (under developed)	1 day	FCHVs, Mothers groups, traditional healers, political leaders, VDC members, teachers, club members	PRIME Intervention Coordinator/ Community Counselor
3.2 Community informant case detection	PRIME-Nepal CIDT training manual	2 days	FCHVs, Mothers groups	Intervention Coordinator/ Community counselor

Component	Training materials	Days of training	Participants	Trainer
3.3 Focused psychosocial support	TPO Nepal Basic Counseling Training manual Adapted PREMIUM manuals for Behavior Activation and Motivational Interviewing (PACT-HD, PACT-DD) Adapted British Columbia Schizophrenia Society manual for Family Support for Psychosis HealthNet TPO SFCI manual for parenting intervention for childrenwith behavioral problems THP manual for maternal depression	3 months	Community Counselor	TPO Master Trainer
3.4 Stigma reduction	GCC stigma reduction packages under development	2 days	TBD	TBD
3.5 User group mobilization through patient support groups	GCC Patient Support Groups *(under development)*	4 days	Service users	TBD

VI. Training structure



Motivational Interviewing (MI), Behavior Activation (BA), Depression Disorder (DD), Harmful Drinking (HD), Family Support for Psychosis (FAM-PSY), Think Healthy Program (THP), Stepped Family Care Intervention (SFCI)

VII. Supervision structure

Type of supervision	For whom?	By whom?	How/where?	Issues
Managerial supervision	Health facility staff	DPHO focal person	Quarterly by DPHO focal person at each health facility; review charts and HMIS*and LMIS*	Financial (per diem and travel)
Psychiatrist case conference supervision	All PRIME trained prescribers of respective health facility	Psychiatrist	Question answer or two way interaction DPHO or TPO office	MOU with district hospital.
Individual psychosocial supervision	All HW who are working in Health facility and already received training from TPO.	Community counsellor	In their own HF	
Group Psychosocial supervision	All PRIME trained health facility staffs (non / prescriber)	Community Counselor	On-site supervision on monthly basis and as per need at health facility.	Need to obtain authority from DPHO for Counselor to supervise government staff.
Clinical psychosocial supervision	Community Counselors	Clinical supervisior of TPO	One time in each 40 days at TPO office Chitwan.and Skype supervision in once a week.	Availability of supervisor
Supervision of CIDT	FCHVs/ MGS	Community counselor/ intervention coordinator	On monthly basis at each health facility	

VIII. Descriptions of Packages

1.	HEALTH ORGANIZATION PACKAGES

1.1.	Engagement & advocacy
Rationale	Mental health is currently not a government priority, therefore advocacy among the policy makers and planners is necessary to develop and implement mental health related activities in Nepal.
Goal& objectives	To sensitize national and district level's leaders about the need for integration of mental health care into primary health care and develop support within the health system for integrated care.
Primary target group	• Division of Policy, Planning and Foreign Cooperation, Ministry of Health (MoH) • Department of Health Services (DoHS) • PHC Revitalization Division • Family Health Division (FHD) • Mental Hospital • National Health Training Centre (NHTC) • Mental health organizations (CVICT Nepal, CMC Nepal, KOSHISH Nepal, LEADS Nepal)
Secondary target group	• Regional Health Directorates • District Public Health Officer (DPHO) • Mental health focal person from DPHO
Content & activities	Discussion and distribution of information package about integration of mental health care into primary health care.
Implementation procedure	1. Coordinate with relevant organizations/departments and select participants 2. Plan workshop 3. Organize information kit 4. Conduct workshop 5. Conduct follow-up meetings
Resource materials	1.1a.WHO Policy document (Organization of Services for Mental Health module) 1.1b.Information kit about mental health *(not available yet)*
Training (days and trainer)	Half day workshop.
Supervision	N/A
Maternal mental health	Undertake advocacy related to mental health among organizations working on maternal health *(e.g.* Maternity Hospital *(Thapathali),* MIRA, etc.)
Indicators	• Understanding of rationale for integrating mental health in primary health care among health organization stakeholders • Participation by key MoH and NGO actors in advocacy for integration of mental health in primary health care?

1.2.	Referral for diagnosis and inpatient care
Rationale	Proper diagnosis and specialized care for peoplewith severe and persistent mental disorders is not available in the Primary Health Centres (PHCs.)
Goal & objectives	To ensure that referred cases receive: (a) Diagnosis by mental health professional for severe and complicated cases (b) Provision of in-patient tertiary care for patients with severe mental health problems
Provider	District Hospital Psychiatrists (public)
Secondary provider	• Medical colleges (private) • Centers for drug rehabilitation (detoxification program) and inpatient care for severe mental Disorders (e.g. HELP Nepal)
Content & activities	• Assessment, diagnosis, and psychiatric treatment for outpatient in OPD • Assessment, diagnosis, and treatment for in-patient care • Rehabilitation services for substance abuse disorders and severe mental disorders
Implementation procedure	1. Coordinate with District Hospital and identify participants 2. Develop and sign MOU between District Hospital and TPO Nepal 3. Develop and conduct orientation on referral process for mental health OPD and psychiatric ward staff 4. Develop referral and feedback slips 5. Hold follow-up meetings
Resource materials	1.2a. Referral slips
Training (days and trainer)	Orientation meeting
Supervision	N/A
Maternal mental health	N/A
Indicators	• Referral / back-referral consultation system operational • Number of people with mental disordersreferred from primary health care facility to hospital • Number of referred people with mental disorders receiving treatment at hospital by psychiatrist • Number of people on psychotropic treatment who experience reduction in symptoms • Number of people with severe mental disorders showing improvements in condition • Level of satisfaction from PHC and specialist mental health services

2.	HEALTH FACILITY PACKAGES

2.1.	Service provider awareness and stigma reduction
Rationale	Stigma and discrimination associated with mental health problems and services is very high among the general populations as well as health care providers. Awareness program is needed to increase mental health literacyand decrease stigma.
Goal & objectives	(a) To increase knowledge about mental health problems and services among all health facility staffs (b) To change the perception of health worker towards mental health and reduce mental health stigma among health facility staffs
Provider	Prescribers
Secondary provider	Non-prescribers
Content & activities	• mhGAP Basic Course for primary health care providers (prescribers) • Mental health sensitization training for secondary providers (non-prescribers) • Stigma Reduction Package (eg. IEC materials) for primary & secondary providers
Implementation procedure	1. Identify health worker for training consultation with DPHO 2. Schedule training, hire trainer 3. Orient trainer to training materials 4. Conduct training according to schedule 5. Distribute PRIME manual to the trainees 6. Evaluate training 7. Develop and conduct refresher training
Resource materials	2.1a.mhGAP Training Materials *(Nepali)* 2.1b.Facilitator Manual for Community Health Workers (BasicNeeds) 2.1c.Flowchart pictures 2.1d.Stigma reduction package (to be developed under GCC program)
Training (days and trainer)	• 2 days *(level 1)* • Trainer for prescribers: Psychologist, Psychiatrists • Trainer for non-prescribers: Intervention Coordinator
Supervision	N/A
Maternal mental health	Half -hour session on maternal depression for secondary health care providers
Indicators	• Number of health workers trained in mental health training • Health worker knowledge of mental health and disorders • Number of health workers participating in community sensitization and awareness activities • Health workers demonstrate positive attitudes towards people with mental disorders • Health workers demonstrate positive behaviors when providing treatment and care for people with mental disorders

	• Level of service user satisfaction with services
2.2.	**Screening & assessment**
Rationale	Currently people with psychosocial and mental health problems who visit PHC are not identified and diagnosed.
Goal & objectives	To identify cases with psychosocial and mental health problems, especially DD, AUD, PSY, EPL,
Provider	Prescribers
Secondary provider	N/A
Content & activities	• Screening and assessment of patient with DD, AUD, PSY, EPL, • Determining whether patient needs basic psychosocial support, focused psychosocial support and/or medication • Maintenance of treatment registers, prescription slips and referral slips • Emergency management and referral to District Hospital for patients needing tertiary care
Implementation procedure	1. Provide training on priority mental disorders to health workers 2. Coordinate with district hospital for exposure visits 3. Undertake exposure visits to government hospital OPD and psychiatric ward for health worker practice in assessing patients (during training) 4. Trainees use mhGAP guideline while assessing patients 5. Doctors lead case discussions to determinehealth worker ability to correctly assess case 6. Provide mhGAP guideline in primary health care facility forassessment and detection of patients with psychosocial/mental health needs 7. Distribute poster/flowcharts of 4priority mental disorders in OPD to facilitate health worker assessment of patients 8. Health workers maintain mental health cases in OPD register 9. Health workers submit monthly reports of detected cases to DPHO and TPO
Resource materials	• mhGAPTraining Materials *(Nepali)(see 2.1a)* • Flowchart pictures*(see 2.1c)*
Training (days and trainer)	• Part of 5 day mhGAP training *(level 3A)* • Trainer: Psychiatrist
Supervision	• Peer supervision between health workers on a bi-weekly basis • PHC doctor supervises health workers on a bi-weekly basis at health facility • Psychiatrist supervises on a monthly basis at DPHO through case conference
Maternal mental health	• Nursing staff will use CIDT of maternal depression for all ANC / PNC mother to detect maternal depression. • Include one session for maternal mental health in training course
Indicators	• Number of health workers participating in training in priority mental disorders

	• Health workers regularly use mhGAP guidelines to assess cases • Number of people correctly identified and diagnosed with priority mental disorders • Health workers maintain updated mental health register
2.3.	Basic psychosocial support
Rationale	Basic psychosocial support required for those patient who have psychosocial and mental problem to strengthen their coping mechanism and to provide emotional support.
Goal & objectives	To ensure that: (a) Health workers provide effective psycho-education and basic emotional support to patients and their families. (b) Patients and family members understand their condition and care plan.
Provider	Prescribers
Secondary provider	Non-prescribers
Content & activities	• Provision of psycho-education to patient and family (what are psychosocial and mental health problems, causes and effect of problems, stress management, coping and self-help strategies) • Provision of emotional support (empathetic listening, reactivating social networks, addressing stressors) through all patient contacts
Implementation procedure	1. Train health workers 2. Manage room with privacy in each health facility 3. Provide IEC materials at health facility for psycho-education 4. Provide psychosocial support to both patient and their caregivers in health facility
Resource materials	2.3a. TPO Nepal CPSW manual 2.3b. IEC materials for psycho-education
Training (days and trainer)	• 2 day training*(level 2)* • Trainers: Psychologist/Community Counselor
Supervision	• Community Counselor supervises prescribers and non-prescriber on monthly basis at health facility. • Community counselor provides individual or other supervision as per need at the health post level.
Maternal mental health	• Involvement of maternal health care staff (ANM and MCHW) in basic psychosocial support.
Indicators	• Number of prescribers and non-prescribers trained in basic psychosocial support • Room ensuring privacy is available in health facility • Number of people receiving basic psychosocial support

2.4.	Focused psychosocial support
Rationale	Focused psychosocial support is required if there is insufficient improvement after providing basic support and in combination with psychotropic medication.
Goal & objectives	To provide effective focused problem-based psychosocial support to patients and/or their families.
Provider (incl. time allocation)	• Non-prescribers (for BA + MI)
Secondary provider	N/A
Content & activities	• Behavior Activation for patients with depression • Motivational Interviews for Alcohol Use Disorder (AUD) • Thinking healthy program for maternal depression
Implementation procedure	1. Select participants, who have already received level 1 & 2 training courses, for further training 2. Finalize trainer. 3. Provide disorder specific psychosocial support training for health workers 4. Health workers provide focused psychosocial support to patients 5. Prescribers refer patients to non prescriber for Behavior Activation for depression and non-prescribers refer patients to prescribers for Motivational Interviewing for AUD 6. Health workers record and reporting mental health OPD register 7. Patients are referred to Community Counselor if more intensive support is required 8. Community Counselor provides ongoing support and supervision to health workers
Resource materials	2.4a. Adapted PREMIUM manuals for Behavior Activation (PACT-DD) 2.4b. Adapted PREMIUM manuals for Motivational Interviewing (PACT-HD)
Training (days and trainer)	• BA *(level 3B) (Brief version)* • MI *(level 3B) (Brief version)* • *Thinking Healthy Program (level 3B)* • Trainer: Psychologist and community psychosocial counselor
Supervision	• Community Counselor provides supervision to non-prescriber and prescriber on a monthly basis
Maternal mental health	• Train on Thinking healthy program to nursing staff for maternal depression Involvement of maternal health care staff (ANM and MCHW)in focused psychosocial support for depression (THP
Indicators	• Number of prescribers and non-prescribers trained in focused psychosocial support • Number of people receiving focused psychosocial support who experience reduction in symptoms

	• Level of service user satisfaction with services
2.5.	Psychotropic treatment
Rationale	A proportion of people having severe and persistent mental health problems need psychotropic treatment.
Goal & objectives	To ensure that prescribers appropriately prescribe psychotropic drugs for severe mental health problems and priority mental disorders (primarily DD, AUD, PSY and EPL)
Provider	Prescribers
Secondary provider	N/A
Content &activities	• Taking detailed medical history of patient in order to prescribe medication • Initiation of psychotropic medication with the patient • Explanation of duration, time, complications, side effects and follow-up of psychotropic medicine to the patient and their family • Referral of patient to the District Hospital if patient does not respond to medicine or experiences severe side effects does not respond
Implementation procedure	1. Conduct training for health workers on priority mental disorders and appropriately prescribing medicine 2. Distribute manual and flowcharts of priority mental disorders to display in OPD 3. Prescribers prescribe medicine to patients 4. Health workers record and report psychotropic treatment in mental health OPD register and reporting form 5. Prescribers provide psycho-education about psychotropic drugs to patient and caregiver 6. Prescribers refer patients to District Hospital if patient doesn't respond to medication or experiences severe side effects 7. Prescribers ensure follow-up of treatment
Resource materials	2.5a. Essential drug list of Nepal 2011 • *mhGAP training materials(draft) (2.1a)*
Training (days and trainer)	• Part of 5 day mhGAP training *(level 3A)* • Trainer: Psychiatrist
Supervision	• Psychiatrist supervises on a monthly basis at DPHO through case conferences to all prescribers. • DPHO focal person for logistics, (drugs) review charts, OPD and drug stock registers on a tri monthly basis
Maternal mental health	Consultation and referral with psychiatrist for ante-natal care (ANC) and post-natal care (PNC) mothers; continuation of treatment from health facility as needed.
Indicators	• Number of prescribers participating in training on prescribing psychotropic medication • Number of people receiving psychotropic treatment • Number of people on psychotropic treatment who experience reduction in symptoms • Number of people referred to district hospital

Remarks	Advanced training for DPHO focal persons related to supervision.
2.6.	**Continuing care**
Rationale	People having mental health problems often are in needof prolonged care under guidance of a health worker.
Goal & objectives	To provide follow-up, case-management and continued services to patients.
Provider	Prescribers and non-prescribers
Secondary provider	N/A
Content & activities	• Assessment of patient symptoms and continuation of psychotropic medication and psychosocial support • Tracing defaulting cases and follow-up to re-engage in treatment • Patient referral to the District Hospital and rehabilitation centers if no improvement and to prevent complications
Implementation procedure	1. Train health workers in mhGAP, and provision of basic psychosocial and focused psychosocial support 2. Health facilities provide psychosocial and psychotropic treatment services regularly 3. Health workers record patient details in OPD register for follow-up 4. FCHVs follow-up on defaulting cases 5. Continue psychotropic treatment, basic and focused psychosocial support to the patient as long as needed 6. Educate patients about recurrence of symptoms 7. Discharge after improvement of patient condition
Resource materials	• mhGAP *training materials (draft)(2.1a)*
Training (days and trainer)	• Part of 5 day mhGAP training *(level 3A)* • Trainer: Psychiatrist • FCHV training on follow-up of defaulting patients
Supervision	• Psychiatrist supervises on a monthly basis at DPHO through case conferences • DPHO focal person for logistics (psychotropic drugs). • Community counselor supervises monthly basis as per need to prescriber and non prescriber.
Maternal mental health	
Indicators	• Number of people receiving regular treatment • Number of defaulting patients • Number of defaulting patients followed up on • Discharge rate
• **Remarks**	• If patient don't come on requested follow up date at least for 1 month than s/he will be recorded as defaulter, if those defaulter cases didn't come for 3 months continuously than they will be discharged and if patient condition improved and they did not need treatment than they will also discharged.

3.	COMMUNITY PACKAGES

3.1.	Mass sensitization
Rationale	High levels of unawareness, stigma and discrimination are associated with mental illness; mass awareness program is needed to help increase mental health literacy.
Goal & objectives	To increase knowledge within the community about mental health and psychosocial problems and available services
Provider	Female Community Health Volunteers (FCHVs)
Secondary provider	• Mothers' groups • Traditional healers • Teachers • VDC secretary • Political leaders • Social mobilizers and other members of CBOs
Content & activities	• Sensitization of community key stakeholder, mothers' group members, teachers , traditional healers and other stakeholders towards mental health conditions and available services at health facilities • Distribution of IEC materials (leaflets, posters, PRIME brochure etc.)
Implementation procedure	1. Coordinate with Village Development Committee (VDC)and District Development Committee (DDC)for participant selection 2. Conduct first phase orientation program for key stakeholders on mental health, services available in VDC, stigma and discrimination related to mental health problems 3. Involve DPHO focal person and health-in-charge in first phase of sensitization program 4. Conduct second phase sensitization program with mothers groups during regular meetings in all wards of selected VDCs 5. Conduct third phase sensitization program for teachers 6. Conduct fourth phase sensitization program for traditional healers 7. Involve FCHV in second -in fourth phase sensitization programs.
Resource materials	3.1a. IEC materials
Training (days and trainer)	• 2- 3 hr orientation programs • Trainer: Intervention Coordinator/Community Counselor
Supervision	Community counselor
Maternal mental health	• N/A
Indicators	• Number of community members participating in sensitization orientations • Knowledge among community members of psychosocial and mental health problems and available services

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3.2	**Community informant case detection**
Rationale	Availability of mental health services is insufficient to ensure access to care. Improved community detection is required to facilitate access to care, in addition to awareness raising.
Goal & objectives	To identify people with mental health problems within the community and refer to health facility.
Provider	• FCHVs • Mothers' group members
Secondary provider	N/A
Content & activities	• Identification of people with mental health problem in the community using the Community Informant Detection Tool (CIDT) • Referral of people with mental health problem to the health facility
Implementation procedure	1. Selection of community informants following predefined criteria 2. Conduct training of all community informants in selected VDCs 3. Utilization of the CIDT
Resource materials	3.2a. CIDT training manual 3.2b. CIDT instrument
Training (days and trainer)	• 2 day training (one day mental health awareness, one day CIDT) + 1 day training for community sensitization program (Micro teaching). • Trainer: Intervention Coordinator or Community Counselor in presence of the health in-charge
Supervision	
Maternal mental health	
Indicators	• Number of community informants participating in training • Number of community informants able to effectively use CIDT to identify referrals • Number of people referred to health facilities by FCHVs as a result of CIDT • Number of CIDT-referred cases with confirmed positive diagnosis at PHC level • Number of community sensitization program conducted by FCHVs.

3.3.	Focused psychosocial support
Rationale	Focused psychosocial support is required if there is no improvement after providing basic support and/or psychotropic treatment. As health facilities cannot always be easily reached and because health workers have limited time, trained Community Counselors can provide ongoing focused psychosocial support within the community. In addition, Community Counselors will have more comprehensive training and skills in a broad continuum of psychological treatment components.
Goal & objectives	To ensure provision of effective focused psychosocial support to patients and their families in a community setting.
Provider	Community Counselor
Secondary provider	N/A
Content & activities	• Generic problem solving counseling (skills, concept and process) • Behavior Activation for depression • Motivational Interview for Alcohol Use Disorder • Family support for psychotic patient • Psychosocial support for postnatal depression • Parent Management Training interventions for children with behavioral problems
Implementation procedure	1. Select Community Counselors 2. Train Community Counselors 3. Community Counselors provide focused support to patients and their families referred from health facilities 4. Community Counselors keep records and report to PRIME Clinical Supervisor 5. Community counselors refer clients to health facility if in need of psychotropic treatment and/or referral to professional mental health care 6. Conduct refresher training
Resource materials	3.3a. TPO Nepal Basic Counseling Training manual 3.3b. Family Support (FAM) for psychosis 3.3c. Stepped Care Family Intervention (SCFI) 3.3d. Thinking Healthy Program (THP) • PACT-DD*(2.4a.)* • PACT-HD *(2.4b.)*
Training (days and trainer)	• Basic Counseling Training for 2-4 months • 25-day training in specific focused psychosocial components (MI, BA, FAM, SCFI, THP – 5 days per component) • Trainer: TPO Master Trainer
Supervision	Clinical Supervisor of TPO
Maternal mental health	Thinking Healthy Program

3.3.	**Focused psychosocial support** *(cont'd)*
Indicators	• Number of Community Counselors trained and able to effectively conduct focused psychosocial support and use specialized tools • Number of people with mental disorders receiving focused psychosocial support from Community Counselor • Number of people receiving focused psychosocial support who experience reduction in symptoms • Level of service user satisfaction with services
Remarks	Currently Nepal's health structure does not include any counselor positions. PRIME Nepal will pilot-test the feasibility of incorporating a trained Community Counselor within Nepal's District Health System for provision of focused psychosocial care in the community.

3.4.	**Stigma reduction**
Rationale	High levels of stigma and discrimination are associated with psychosocial and mental health problems; therefore a comprehensive stigma reduction strategy and activities are needed.
Goal & objectives	To reduce stigma and discrimination towards people with mental health problems in the community.
Provider	Will follow/adapt TPO Nepal's Grand Challenges Canada (GCC) Mental Health Beyond Facilities Project model (mhBeF) (*under development)*
Secondary provider	N/A
Content & activities	Will follow/adapt GCC mhBeF model *(under development)*
Implementation procedure	Will follow/adapt GCC mhBeF model *(under development)*
Resource materials	3.4a. GCC mhBeF Stigma Reduction Package *(under development)*
Training (days and trainer)	Will follow/adapt GCC mhBeF model *(under development)*
Supervision	Will follow/adapt GCC mhBeF model *(under development)*
Maternal mental health	
Indicators	• Number of service users participating in stigma reduction activities • Attitudes towards people with mental disorders • Community members demonstrate positive and supportive behaviors when interacting with people with mental disorders

3.5.	User group mobilization through patients support group
Rationale	Patient support groups are a low-intensity form of psychosocial support aimed at enhancing sharing of problems and related coping- and self-help strategies among a group of people with similar psychosocial or mental health problems. User group mobilization will facilitate effective advocacy on mental health for policy development, motivating and linking up other mental health patients to the health facility.
Goal & objectives	• To motivate and link other mental health patients to health facilities • To increase social and peer-to-peer support • To advocate about mental health
Provider	Service users with help of Community Counselors in initiating groups
Secondary provider	N/A
Content & activities	• Formation of user support groups in the community • Initial facilitation to get support group started, followed by handover to group • Sharing feelings and experiences related to common problem • Helping other people suffering from mental health problem in the community • Micro-credit scheme to promote income generation • Advocacy for mental health for policy formation and for rights of people experiencing mental health problems
Implementation procedure	Will follow/adapt GCC mhBeF model *(under development)*
Resource materials	3.5a. GCC mhBeF Patient Support Groups (PSG) *(under development)*
Training (days and trainer)	Will follow/adapt GCC mhBeF model *(under development)*
Supervision	Community Counselor
Maternal mental health	Forming and implementing Maternal Peer Support Groups
Indicators	• Number of user groups formed and meeting regularly • Number of members in user groups • User group members reporting satisfaction with user group activities • Number of advocacy activities undertaken by user groups

	ENABLING/ FACILITATING PACKAGES

I.	Drug supply chain
Rationale	Currently psychotropic medicine is not available at the health post and sub health post levels, and only two drugs are available at the PHC level. Effective treatment of certain disorders requires local availability of psychotropic drugs.
Goal & objectives	To ensure availability of psychotropic drugs from the Primary Health Care Revitalization Division through the District Health Office to health facilities.
Provider/key actors	• Drug Procurement Department of PHC Revitalization Division • DPHO Drug Procurement Committee.
Content & activities	• Regular budgeting for psychotropic drugs by the Ministry of Health through the PHC Revitalization Division. • Mechanism for regular and reliable supply and monitoring of drugs.
Implementation procedure	1. Allocation of(separate) budget for psychotropic medicine from PHC Revitalization Division to DPHO 2. Review and adapt existing drug protocol for psychotropic medicine, in collaboration with MoH 3. Review legislation and regulations related to authority of primary health workers to prescribe and dispense psychotropic medicines 4. DPHO and PRIME develop projections for psychotropic drugs needed 5. DPHO Drug Procurement Committee holds meetings related to purchase of psychotropic medicine 6. DPHO purchases psychotropic drugs 7. DPHO supplies drugs to health centers 8. PRIME/DPHO undertake regular monitoring to ensure appropriate logistics management related to drug procurement, storage, and supply at health facility and DPHO 9. Develop alternative options if drug supply is not regular in district
Resource materials	Ia. HNTPO Drug Chain Management: Guidelines for Fragile Settings • Essential Drug List 2011*(2.5b.)*
Supervision	DPHO focal person supervises LMIS in health facility
Indicators	• Budget allocated for psychotropic medicine by MoH for DPHO • Psychotropic drugs procured regularly by DPHO • Psychotropic drug stock maintained in DPHO and health facilities • Drug availability in facilities with a provider available at clinic • Number days of 'stock out' for each class of medicine
Remarks	If there is no separate budget from PHC RD to DPHO for psychotropic medicine then more than 2 months required to procure medicine. In this case, PRIME will have to advocate for a separate budget for psychotropic medicine.

II.	Program Management/Health Management Information System (HMIS)
Rationale	There is currently no mental health focal person in the DPHO to oversee a mental health program and services in the district. Health facility staff are not recording mental health information in the HMIS system, because they have not received mental health training.
Goal & objectives	• To ensure regular monitoring by DPHO of mental health services at the district level • To ensure regular collection and monitoring of health information related to mental health care at district level.
Provider/key actors	• DPHO mental health focal person • DPHO Statistics Assistant
Content & activities	• Regular monitoring by DPHO of mental health services at the district level • Regular collection and monitoring of health information related to mental health care at district level.
Implementation procedure	1. Review current HMIS-MH indicators and data, and advocate for additional MH indicators as needed 2. Advocate for appointment of mental health focal person from the existing staff of DPHO. 3. Mental health focal person manages and monitors district mental health program. 4. Train DPHO and health facility staff on HMIS-MH 5. Health workers record activities related to mental health in separate mental health register and MH OPD register on a daily basis 6. Health worker reports monthly to DPHO and TPO 7. DPHO mental health focal person monitors recording and collection of data throughout the HMIS system at district level
Resource materials	IIa. HMIS/Nepal*(to be adapted for mental health under the EMERALD program)* IIb. PRIME developed OPD register
Supervision	DPHO supervises health facility on a monthly basis for implementation of mental health services and HMIS
Indicators	• Number of trainees with competence in new HMIS system • Health workers regularly and accurately record mental health information in the MH OPD register • Health facility submits complete, accurate and timely monthly reports to DPHO

III.	Human resource support, motivation and supervision
Rationale	Because mental health services have not previously been provided through the district primary health system, there is no established supervision system for these services.
Goal& objectives	• To ensure provision of regular mental health service through the district primary health care system • To enhance skills of health staff engaged in mental health care
Provider/ key actors	• Psychiatrist • DPHO mental health focal person • Community Counselor • intervention coordinator • Psychologist (Clinical Supervisors)
Content& activities	• Supervision protocol (guidelines and feedback mechanism) • How to conduct appropriate and effective supervision for mental health services
Implementation procedure	**1.** MoH budget allocation for mental health supervision to DPHO **2.** Train supervisors in clinical supervision **3.** Assign supervisors and schedule supervision **4.** Prescribers undertake peer supervision in health facility in presence of PHC doctor and Community Counselor for mhGAP, basic and focused psychosocial support **5.** Community Counselors provide monthly supervision to non-prescribers for basic and focused psychosocial support **6.** DPHO focal person provides monthly supervision in each facility for HMIS and LMIS **7.** Psychiatrist provide monthly supervision in DPHO through case conferences for all prescribers **8.** Clinical Supervisors provide biweekly or monthly supervision to Community Counselors **9.** Community counselor / intervention coordinator will do monthly meeting with FCHVs and MGs for CIDT data collection and support them.
Resource materials	IIIa. Integrated supervision protocol of MoH IIIb. PRIME supervision protocol for mental health*(under development)*
Supervision	• Psychiatrist • DPHO mental health focal person • Community Counselor • Psychologist (Clinical Supervisors)
Indicators	• Supervision tool in place • All trained supervisors exhibit defined minimum competency in domains • Number regular supervision visits conducted (according to the protocol and established schedule) • Supervisees adequately perform functions on supervision checklist • Supervision Alliance scale filled by supervisee after supervision

IV.	Routine monitoring and evaluation
Rationale	Regular information is needed about the access to and uptake of services, and the quality thereof, in order to assess whether the developed mental health care plan has the intended impact. A well-functioning monitoring and evaluation system can aid in fine-tuning and improving the services.
Goal & objectives	To ensure delivery of quality mental health services at the district level
Provider/key actors	• PRIME Project Coordinator • DPHO • DPHO mental health focal person • PRIME Intervention Coordinator • M& E focal person of PRIME
Content & activities	Routine monitoring and evaluation of all program activities, including: • Client flow and type of problems • Quality of service provision • Service provider distress • Client improvement and progress • Treatment perception • Client satisfaction
Implementation procedure	1. Every new clients or client contact related to mental health will be registered by PHC workers or counselor, using the intake form. 2. Information from these forms get collated into a monthly register to provide update information on uptake and perception of services 3. After every counseling treatment termination the community counselors and client each completes an evaluation form. 4. Every two weeks a research assistants visits PHC (spot-checks), on that day all mental health cases that are non-intake will be followed up with an evaluation form, for both client and PHC worker. 5. Data gets collected by PRIME staff, gets summarized and circulated among DPHO and other involved stakeholders. 6. Regular review of data will be done to translate routine M&E findings into adaptation to service delivery
Resource materials	IVa. Intake form for PHC visits IVb. Intake form for community counselor visits IVc. Evaluation form for PHC workers IVd. Evaluation form for counselors IVe. Evaluation form for clients(both PHC and counseling)
Supervision	N/A
Indicators	• M&E system for implementation of district MHCP is in place and used to get feedback and improve care • Number of monitoring visits undertaken

V.	Community integration: inter-sectoral linkages
Rationale	People with mental health problems need a range of services (e.g.. livelihoods)besides mental health support to successfully (re)integrate into their communities.
Goal & objectives	To engage organizations (government, NGOs, CBOs) working in non-health sectors (e.g. livelihoods)in the support and integration of people with (severe) mental health problems.
Provider	• Governmental organizations • Non-governmental organizations
Secondary provider	N/A
Content & activities	• Community resource mapping and mobilization. • Linking with different organizations who are providing livelihood support in VDC and district.
Implementation procedure	1. Map organizations working in livelihoods in district 2. Coordinate and share information with different organizations 3. Develop sensitization package for these organizations 4. Conduct sensitization activities 5. Community Counselor and/or other health workers link patient to those organizations (referral, escort, advocacy) 6. Community Counselor provides follow-up support to facilitate successful integration of referred persons in program
Reference	Va. Community Systems Strengthening (HNTPO) Vb. Basic Needs/India
Training (days and trainer)	
Supervision	Community Counselor undertakes at least one on-site follow-up visit to placement site, and more if needed
Maternal mental health	N/A
Indicators	• Number of collaborating programs/organizations • Number of persons placed in livelihoods programs • Number of persons who successfully complete program • Number of persons who are earning as a result of participation in program

IX. Human resource matrix

	Health org level	Health facility level								Community level						
Package	PSY	PHI	MO	SN	HA	AHW	VHW	ANM	MCHW	FCHV	TH	MG	TEC	VDCS	CC	SU
1.1																
1.2	✓															
2.1		✓	✓	✓	✓	✓	✓	✓	✓							
2.2		✓			✓	✓										
2.3		✓	✓	✓	✓	✓	✓	✓	✓							
2.4		✓	✓	✓	✓	✓	✓	✓	✓							
2.5		✓			✓	✓										
2.6		✓	✓	✓	✓	✓	✓	✓	✓	✓						
3.1										✓	✓	✓	✓	✓		
3.2										✓		✓				
3.3															✓	
3.4										✓	✓		✓			✓
3.5															✓	✓

PSY=Psychiatrist

PHI=Public Health In-Charge;
MO= Medical Officer;
SN=Staff Nurse;
HA=Health Assistant;
AHW=Auxilliary Health Worker;
VHW=Village Health Worker;
ANM=Auxilliary Nurse Midwife;
MCHW=Maternal and Child Health Worker

FCHV=Female Community Health Volunteer;
TH=Traditional Healer;
MG=Mothers' Group;
TEC=Teacher;
VDCS=Village Development Committee Secretary;
CC=Community Counselor
SU=Service User

X. Reference Materials: Content of the MHCP

Component	Document	Source	Available in Nepali?
Health organization packages			
1.1	1.1a. WHO Policy document (Organization of Services for Mental Health module) 1.1b. Information kit about mental health *(not available yet)*	WHO [ud]	No No
1.2	1.2a. Referral slips	MoH Nepal	Yes
Health facility packages			
2.1	2.1a. mhGAP Training Materials 2.1b. Facilitator Manual for Community Health Workers 2.1c. Flowchart pictures 2.1d. Stigma reduction package (under development)	WHO mhGAP IG Basic Needs, India WHO mhGAPIG mhBeF SR	Yes No Yes No
2.2	• mhGAP Training Materials *(2.1a)* • Flowchart pictures*(2.1c)*	WHO mhGAP IG WHO mhGAPIG/ TPO N	Yes Yes
2.3	2.3a. TPO Nepal CPSW manual 2.3b. IEC materials for psycho-education	TPO N UCT PNP	Yes Yes
2.4	2.4a. Adapted PREMIUM manuals Behavior Activation (PACT-DD) 2.4b. Adapted PREMIUM manuals Motivational Interviewing (PACT-HD)	Sangath, India/LSHTM Sangath, India/LSHTM	Yes Yes
2.5	2.5a. Essential drug list of Nepal 2011 • mhGAP training materials *(draft) (2.1a)*	MoH Nepal WHO mhGAP IG	Yes Yes
2.6	• mhGAP training materials *(draft) (2.1a)*	WHO mhGAP IG	Yes

Community packages			
3.1	3.1a IEC materials	UCT PNP	Yes
3.2	3.2a. CIDT training manual 3.2b. CIDT instrument	PRIME Nepal PRIME Nepal	Yes Yes
3.3	3.3a. TPO Nepal Basic Counseling Training manual 3.3b. Family Intervention manual for psychotic symptoms 3.3c. Stepped Care Family Intervention (SCFI) 3.3d. Thinking Healthy Program (THP) • Adapted PREMIUM manual Behavior Activation (PACT-DD) *(2.4a)* • Adapted PREMIUM manual Motivational Interviewing *(2.4b)*	TPO Nepal British Columbia Schizophrenia Society HealthNet TPO University of Liverpool Sangath, India/ LSHTM Sangath, India/ LSHTM	Yes No No No Yes Yes
3.4	Will follow/adapt GCC mhBeF model *(under development)*	mhBeF SR	No
3.5	Will follow/adapt GCC mhBeF model *(under development)*	mhBeF PSG	No
Enabling/facilitating packages			
I	Ia. HNTPO Drug Chain Management: Guidelines for Fragile Settings • *Essential Drug List 2011 (2.5b.)*	HealthNet TPO MoH, DoHs	No
II	IIa. HMIS/Nepal IIb. OPD register for mental health	MoH Nepal/ EMERALD PRIME Nepal	No Yes
III	IIIa. Integrated supervision protocol of MoH IIIb. Supervision protocol for mental health	MoH PRIME Nepal	No No
IV	IVa. Intake form for PHC visits IVb. Intake form for community counselor visits IVc. Evaluation form for PHC workers IVd. Evaluation form for counselors IVe. Evaluation form for clients (both PHC & counseling)	PRIME Nepal PRIME Nepal PRIME Nepal PRIME Nepal PRIME Nepal	Yes Yes Yes Yes Yes
V	Va. Community Systems Strengthening Vb. Mental Health and Development Model	HealthNet TPO Basic Needs/India	No No

Name of psychotropic medicine supplied from DPHO

S.N.	Mental health problem	Name of Medicine
1	Depression	Cap Fluoxetine 20 mg
2	Psychosis	Tab Resperidone 2 mg
3	Epilepsy	Tab Carbamazepine 200 mg
4	Alcohol used disorder	Tab Diazepam 5 mg / 10 mg
5	Alcohol used disorder	Tab Thiamine 100 mg
6	Psychosis	Tab Trihexiphenidil 2 mg