Health Sector Transition and Recovery Programme

120 Prescribers Trained on mhGAP HIG

TPO Payment Deliverable 3

Transcultural Psychosocial Organization

TPO Nepal
PEACE OF MIND

NHSSP

UKaid
from the British people

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This report is submitted in accordance with Transition and Recovery Programme (TRP) payment deliverable PD TPO 3: 120 (60 in each district) prescribers trained on mhGAP HIG.

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Cover photo courtesy of DFID.

120 PRESCRIBERS (60 IN EACH DISTRICT) TRAINED ON MHGAP HIG

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LIST OF ACRONYMS

DFID	Department for International Development (UK Aid)
DHO	district health office
DoHS	Department of Health Services
DPHO	district public health office
GoN	Government of Nepal
MoHP	Ministry of Health and Population
NGO	Non-government organisation
NHSP-2	Second Nepal Health Sector Programme (2010–2015)
NHSSP	Nepal Health Sector Support Programme
PRIME	Program for Improving Mental Health Care
TPO	Transcultural Psychosocial Organization
mhGAP HIG	Mental Health GAP Humanitarian Intervention Guide
MHPSS	Mental Health and Psychosocial Support
GPC	General Principal of Care
PTSD	Post Traumatic Stress Disorder
CIDT	Community Informant Detection Tool
FCHV	Female Community Health Volunteer

1. BACKGROUND and OBJECTIVES

1.1 Mental Health in Nepal

WHO (2008) estimates that neuropsychiatric disorders in Nepal contribute to around 11.0% of the global burden of disease (WHO, 2008) yet the country as a whole suffers from a great shortage of mental health (MH) services. The country has only 0.22 psychiatrists and 0.06 psychologists per 100,000 people (Luitel et al, 2015).

An officially approved mental health policy exists and was most recently revised in 2004, but it has not been fully implemented. Mental health is not specifically mentioned in the general health policy and there is no mental health legislation or plan.

Rural areas, where 80% of Nepal's population lives, tend to suffer most from this under resourcing since most MH services are concentrated in large cities. The earthquake of April, 2015 has had a major and enduring impact on the psychosocial and mental health of individuals, families, and communities in the worst affected districts and has significantly increased the need for mental health services in these areas. The delayed presentation of post traumatic stress related symptoms is of particular relevance here.

While the need for mental health treatment and counselling has increased markedly, the Ministry of Health (MoH) has very few resources available to address the issue. Total MH expenditures comprise less than 1% of the total health budget and therefore limit the number of specialists on staff. For this reason, the capacity building of general health workers in earthquake affected districts is essential if services are to be made available in the areas of greatest need.

In the pathways of care system, people with psychiatric illnesses travel to a nearby health post or primary health care centre (PHCCs) and follow the guidance provided by health workers posted there. These tend to be medical officers, health assistants, community medical auxiliaries (CMAs) and auxiliary health workers (AHWs). As noted, addressing mental health issues through the training of local health workers is essential.

In order to manage the different mental health problems of people in various communities affected by the earthquake, prescribers, in particular, can play a vital role. While there exists a preconception that prescribers can only prescribe medicines, in recent years a gradual shift has taken place in accepting that prescribers should possess some psychosocial knowledge including an ability to teach simple relaxation techniques to help patients manage stress. They also need good communication skills and the ability to lend emotional support to people with mental health issues.

With the overall purpose of better integrating mental health services into the government's existing health care system, TPO is working in close coordination with district health offices (DHOs) to help

build the capacity of government service providers. The training for this is based on the Mental Health GAP (mhGAP) programme of the World Health Organization (WHO) and the prescription modules are based on the mhGAP Humanitarian Intervention Guide (HIG), developed for prescribers in middle to low income countries where specialist care from psychiatrists is not available.

1.2 Mental Health in Nepal's Post Earthquake Context

In general, people in communities following a natural disaster such as an earthquake are in a vulnerable psychological state and in need of mental and psychosocial services. For these reasons 141 prescribers (71 in Ramechhap and 70 in Dolakha district) were trained on mhGAP HIG through the DFID supported Nepal Health Sector Transition and Recovery Programme (TRP) under the Nepal Health Sector Support Programme (NHSSP).

1.3 Purpose and Objectives

The overall purpose of the training was to integrate mental health services into the primary health care setting. The specific objectives were:

- To build the capacity of prescribers to diagnose mental health problems in the primary health care settings
- To build the capacity of prescribers to provide pharmacological treatment for people with mental health problems
- To enable prescribers to provide psychosocial support including psychos-education and counselling support
- To enable prescribers to identify and refer cases requiring specialist care.

2. METHODOLOGY

2.1 Preparation of Training and Reading Materials

We adopted the training manual developed by PRIME (Programme for Improving Mental Health Care), a multinational research project being conducted in five low and middle income countries namely Ethiopia, India, Nepal, South Africa, and Uganda. This manual proposes nine-days training on the integration of psychosocial and mental health in primary health care centres for prescriber level health workers such as medical officers, and health assistants.

This model was replicated in post-earthquake setting in two other districts by TPO Nepal under a project funded by International Medical Corps (IMC). The PRIME module follows the mental health gap action program (mhGAP) general version, whereas, in this project we used mhGAP-HIG (humanitarian version) where post-traumatic stress disorders and acute disorders were added.

These observations, feedback and discussions from these programmes provided an opportunity to improve the design of the course curriculum, content, learning materials and training methodologies. Accordingly training slides, course materials and hand outs were updated and translated into Nepali for use under the TRP. A summary of changes made appears as Annex 2. Some changes to the content were also made following discussions with NHSSP's clinical supervisor, several consultant psychiatrists from TPO Nepal, psychologists, and psychosocial counsellors.

2.2 The Selection of Health Workers

With the purpose of expanding mental health services in government health facilities, the project's aim is to train at least one prescriber level health worker from each facility. Accordingly, discussions were held with the DHO and concerned focal persons in each district to select appropriate health workers. The participants list was then finalised by the DHO team.

The DHOs in both districts played an important role in selecting the training participants, communicating details of the training programme to them and deciding on the training venue. Regular supervision and monitoring of the training was provided by the chief of the DHO and concerned focal persons. Each training session had a maximum of 25 participants.

In Dolakha district, all health facilities except one health post were covered. Thus participants came from one district hospital, one primary health care centre (PHCC), and 52 out of 53 health posts making a total of 70 prescribers.

In Ramechhap district, 71 participants from 48 out of 56 health facilities were trained including representatives from the district hospital, three PHCCs, and 43 health posts. Not all of the health facilities could be covered for several reasons including the unavailability of health workers, the

running of other trainings concurrently, and the absence of health workers etc. The prescribers trained were medical officers, health assistants, CMAs and AHWs.

In Ramechhap, five trainees were medical officers and 66 others were prescribers (such as health assistants, auxiliary health workers), whereas in Dolakha 3 trainees were medical officers and 67 others were health assistants, and auxiliary health workers.

2.3 Training Content

The training was conducted over an 8 day period. The first three days were dedicated to the provision of psychosocial support (e.g. communication skills, psycho-education, active listening and emotional support) and following five days to the diagnosis and management of mental health conditions. The detailed content of the training is provided in Annex 1.

2.4 Techniques and Interventions Used During the Training

Several techniques and interventions were used in the training. As with other trainings, power point presentations and mini-lectures were given on various mental illnesses. Group work and discussions were encouraged so that all of the participants would engage and gain similar knowledge. We also focused on role plays which were pivotal in teaching the skills needed for interviewing. We showed several videos with subtitles in Nepali that helped the trainees understand the importance of body language and history taking. Videos of cases of conversion disorder and epilepsy were also shown which demarcated the differences between the two. We also shared case stories drawn from the clinical experiences of the psychiatrists present. Other modalities such as playing games, mini assessments, and brain storming were also used.

In addition, we also invited patients with mental health issues to the training where psychiatrists (trainer) demonstrated to participants how to take a history and carry out mental health examinations. A total of 24 cases were discussed during the training courses.

Case Demonstration in Progress

3. ASSESSMENT OF TRAINING OUTCOMES

3.1 Pre- and Post-testing Participants

A pre-test was carried out before each training session consisting of questions to 1) determine participants' knowledge levels, 2) assess attitudes and perceptions related to mental illness and 3) collect expectations from participants.

After completion of the course, participants were given a post-test where they answered the same set of questions as in the pre-test. Comparing participants' post-test scores with their pre-test scores enabled us to assess whether or not the training was successful in increasing participants' knowledge of the training content.

As a part of the post-test, ENACT (Enhancing Assessment of Common Therapeutic factors) was completed. This is a rating scale that helps rate therapists' competence. Competence is rated on three different sheets by: a) the counsellor who plays the role of a patient; b) the health worker him/herself, and c) other health workers who act as the audience of role plays.

This tool is used for multiple applications such as training evaluations and supervision, selecting trainers, supervisors, and research supervisors, and monitoring common factors in interventions to compare with patient outcomes.

The ongoing assessment involved phone calls received by the psychiatrist under phone supervision, monthly supervision by psychiatrists, the number of cases identified and managed as per the Outpatient Department (OPD) register, the number of cases referred as per the OPD register, and the consumption of psychotropic medications provided.

The results of pre- and post-assessments have been entered into a database and are currently being analysed with the final report due in late March, 2016

4. PLANS FOR SUPERVISION

4.1 Post-training Follow Up

Post-training follow up supervision is currently being planned. Two types of supervision will be provided: phone supervision, where the trained health workers can directly contact psychiatrists for help needed to diagnose and manage cases, and in-person supervision where the psychiatrist will discuss cases directly with participants.

The in-person supervision will be carried monthly when the psychiatrists will visit the districts. Case conferences will be held where the participants will discuss the cases they have seen. They will also be encouraged to bring up difficult cases for specialist care and discussion.

In addition, participants will be encouraged to work in coordination with counsellors and community psychosocial workers from TPO Nepal. They will also work in close coordination with other partners including Handicap International (HI) and the Spinal Injury and Rehabilitation Centre (SIRC) team, both of whom are working in the earthquake affected areas to manage referred cases requiring psychosocial support.

Prescribers Training Session in Progress

5. PLANS VS ACHIEVEMENTS

Planned	Achieved
Developed training material and reading materials	Done
Consultation with Nepali mental health experts to contextualize assessment, diagnosis and management criteria	Done
Finalize mhGAP HIG for use in Nepal	Done
Insert Nepali sub-titles in mhGAP HIG videos	Done
120 prescribers trained in mhGAP HIG	141 Trained

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Annexure 1: Training Content for 8 Days

The following content was covered during the eight days training programme:

Day	Content Covered
1	Pre-testing and psychosocial problems: causes and consequences, psychosocial well-being, Dos and Don'ts of psychosocial support
2	Types of communication skills: basic communication skills, non-verbal communication skills, verbal communication skills, role plays
3	Stress and coping, psycho-education, self-care, stigma, health workers role to support: look listen and link
4	Introduction to mental illness and mhGAP, depression (introduction, assessment, and management)
5	Post traumatic stress disorder (PTSD), anxiety, grief (introduction, assessment, and management)
6	Psychosis (introduction, assessment, and management)
7	Epilepsy and conversion, suicide (introduction, assessment, and management)
8	Alcohol use disorder (introduction, assessment, and management), documentation, post-test, and ENACT

ANNEX 2: ADAPTION OF mhGAP-HIG FOR USE IN NEPAL

Fifteen Nepali psychiatrists, 1 expatriate psychiatrist, 3 TPO Nepall psychosocial staff (including a psychiatric nurse, a counsellor/public health worker, and a research officer), and two expatriate graduate students were involved in the adaptation process.

The following are the major areas of adaptation:

1. **LANGUAGE** – The Nepali version of the mhGAP-HIG was developed for use with health assistants (HAs) and other health care workers. The English version could be used with MBBS doctors, but a Nepali version was clearly more useful. The TPO Nepal/PRIME mhGAP-IG was used as a foundation for some of the translations. A consistent glossary of MHPSS terms in Nepali was developed. Some materials are absolutely necessary in Nepali, in particular the Psychoeducation materials.

2. **RATIONALE** – Why integrate mental health (MH) into primary care and why do it in the context of a humanitarian disaster? Based on psychiatrists' experiences working with primary care workers in Nepal, more information was gathered on the rationale for this endeavour. Case vignettes that resonate with Nepali primary care workers were developed. In addition, prevalence rates of undiagnosed mental health problems in primary care in Nepal were included (e.g., undiagnosed depression and diabetes in Nepal; undiagnosed hypertension and depression in Nepal).

3. **PSYCHOEDUCATION** – For each of the key disorders, we need Nepali language psychoeducation materials so that health workers can consistently explain the conditions using the same terminology and concepts. Therefore, the technical team developed the relevant materials for the psycho education used for health workers.

4. **GENERAL PRINCIPLES OF CARE (GPC)** – An introductory module of mhGAP-HIG is GPC. It was modified to address (1) the role of the family in Nepali culture and in healthcare interactions, (2) management of confidentiality in the context of Nepali clinics and with families, and (3) other culturally appropriate common factors.

5. **MODULES**
    a. CONVERSION DISORDER – Conversion disorder is not adequately addressed in the current mhGAP-HIG. A section has been included in Epilepsy module, including a table on distinguishing seizures and non-epileptic episodes.
    b. SOMATIC COMPLAINTS – The somatic complaints section is very brief in the OTH section, and it risks being dismissive and discouraging use of psychological and other care. It also risks missing organic pathologies in psychiatric patients. This section has been adapted for Nepal to assure the best quality of care.

c. GRIEF – More information on culturally appropriate bereavement has been added.
d. ANXIETY – There is no module on generalized anxiety. The psychiatrists were concerned because this is a common complaint and requires different psycho-education from depression. Moreover, in Nepal, there is epidemiological evidence for different life courses of anxiety and depression that would support treating them differently. In addition, with anxiety, panic attacks mentioned because this is a frequent presenting complaint in Nepal, especially in the context of palpitations and psychogenic cardiac complaints.
e. PTSD – Given the lack of fluoxetine on the free drug list, most clinicians will only have access to amitriptyline. Given that amitriptyline does not have evidence supporting use in PTSD, and in fact has a higher treatment drop-out rate than placebo, similarly, given that alprazolam is the only free drug available for prescription by health assistants, the risks of alprazolam and other drugs in treating PTSD and other disorders were considered while contextualizing the module.