Community Mental Health Care Package
Nepal, 2074

Government of Nepal

Ministry of Health

Department of Health Services

Primary Health Care Revitalization Division

Teku, Kathmandu

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Foreword

It's my immense pleasure to officially introduce ***"Community Mental Health Care Package Nepal, 2074"*** prepared by Primary Health Care Revitalization Division (PHCRD), Teku, Kathmandu. It is aimed to facilitate the implementation of National Mental Health Policy thereby ensuring the availability and accessibility of basic mental health and psychosocial support services through community health care system in Nepal. It provides the outline of mental health and psychosocial support services and training packages at health facilities and community level and also defines the minimum standard of services within the existing system.

This package is guided by the principles for integration of mental health into primary care and is based on WHO Mental Health Gap Action Program (mhGAP), international guideline and standards, evidences based practices and National Mental Health Policy. Beneficiaries of this package are policy makers, public health personnel, political leaders, civil society organizations, individuals with mental health and psychosocial problems and their family members. The package has been prepared with involvement of representatives from Ministry of Health, Department of Health Services, Primary Health Care Revitalization Division, National Health Training Centre, Management division, World Health Organization (WHO), different NGOs working on mental health, academicians and mental health experts -Psychiatrists and Clinical Psychologists.

I hope this package will be highly useful to government and non-government stakeholders in framing the mental health care programs and maintaining the uniformity and standard of the training, mentoring and supervision, mental health and psychosocial support services and quality assurance.

At this moment, I would like to express my sincere gratitude to the entire team members from PHCRD who took an initiative on this issue. I am very grateful to representatives and experts from Transcultural Psychosocial Organization (TPO) Nepal who contributed to the technical content of the care package. Last but not the least, I would like to thank all the representatives from government and non-government organizations, academic institution and mental health experts who showed a great zeal in preparation of this package by providing valuable feedback and suggestions to the draft.

"No health without mental health"

Mohammad Daud
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Foreword

Mental, Neurological and Substance-use (MNS) conditions, which account globally for 13% of all disability adjusted life years lost, are on rise in low- and middle-income countries (LMIC). In Nepal, the most common mental disorders - depression and anxiety disorders - are prevalent in up to one third of the population. Suicides are the leading cause of deaths among women of reproductive age in Nepal, accounting for 16% of deaths among these women. However, almost 9 out of 10 people with MNS condition do not receive the mental health care they need in Nepal. The untreated MNS conditions results in unemployment, poverty, poor physical health, pre-mature mortality, substance abuse and addiction and suicide. There is growing evidence that a scale up of services for common mental disorders is cost-effective and has a positive result on over-all health and people's ability to work.

The need to integrate mental health into general health services and to develop responsive mental health services in community-based settings has been prioritised in the Mental Health Action Plan 2013-2020 and facilitated through WHO's mental health gap action programme (mhGAP). This has also been a national priority as mentioned in Nepal's national Mental Health Policy and in the Multisectoral Action Plan for the Prevention and Control of Non-Communicable Diseases.

However, in the absence of national standards for community mental health services, different approaches have been adopted by various partners. This Community Mental Health Care Package, Nepal, 2074 aims at improving the effective use of resources by better harmonizing different efforts related to community mental health services.

This mental health care package is based on the cumulative national and international experience on the effective delivery of the mental health services by Primary Health Care Centers through task sharing and task shifting approaches. The package provides minimum standards for mental health and psychosocial support services at different levels of primary care. This will also guide health administrators from government or private sector in planning and implementing community mental health activities, which will hopefully result in an increase in access to quality mental health services.

I would like to acknowledge the generous financial support from United States Agency for International Development (USAID) Office for Foreign Disaster Assistance (OFDA) to conduct this activity.

Dr Jos Vandelaer

WHO Representative to Nepal

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Preface

Community mental health services started in Nepal in 1985 AD and have been expanding gradually over different regions of the country especially with a pace after major earthquake of 2015. Since mental health was under less priority of the government, the lack of standardization and uniformity in capacity building of non-specialized mental health professionals, training and clinical mentoring packages, types and quality of metal health and psychosocial support services delivered and minimum standard of care was realized. Primary Health Care Revitalization Division (PHCRD) has been designated as the focal unit for non-communicable diseases including mental health. On this pretext, the "Community Mental Health Care Package, Nepal, 2074" has been prepared to fulfill the existing gap and facilitate implementation of National Mental Health Policy thereby ensuring the availability and accessibility of integrated mental health and psychosocial support services within the primary health care system of the country.

The package broadly defines the mental health care packages at the level of health facility and community along with the implementation mechanisms. It was initiated by PHCRD and supported by World Health Organization (WHO) and Transcultural Psychosocial Organization Nepal (TPO Nepal). The package took an overview of PRogramme for Improving Mental health carE (PRIME) community mental health model at the beginning and underwent a series of reforms through rigorous technical discussions within a team of experts and representatives from government and non-governmental organizations, academicians and mental health professionals, to give the final structure. It considers genuine scientific references and literature on community mental health.

The package is targeted to policy makers, public health personnel, political leaders, civil society organizations, individuals with mental health and psychosocial problems and their family members. This package will be practiced by the government of Nepal from the recent fiscal year to design and implement community based mental health programs in the country. It can also be utilized by other civil society and private organizations for similar purpose without distorting the substance and standards of the package. The individual packages have been well-elaborated in relevant sections for convenience and appropriate understanding. It has been anticipated that this package will act as a milestone in the sector of community mental health in the country.

Acronyms used in the package

AHW: Auxiliary Health Worker
ANM: Auxiliary Nurse Midwife
AUD: Alcohol Use Disorder
BA: Behavior Activation
BDI: Beck Depression Inventory
CAP: Counseling for Alcohol Problem
CBO: Community Based Organization
CC: Community Counselor
CIDT: Community Informant Detection Tool
CMC Nepal: Centre for Mental Health and Counseling Nepal
CPSW: Community Psychosocial Worker
CVICT: Centre for Victims of Torture
DD: Depressive Disorder
EPL: Epilepsy
FAM-PSY: Family Support for Psychosis
FCHV: Female Community Health Volunteer
HA: Health Assistant
HAP: Healthy Activity Program
HMIS: Health Management Information System
IEC: Information Education and Communication
IPD: In-patient Department
LMIC: Low Middle Income Country
LMIS: Logistic Management Information System
MG: Mother's Group
MH: Mental Health
mhBeF: mental health Beyond Facility
MHCP: Mental Health Care Package
mhGAP: mental health Gap Action Programme
MHPSS: Mental Health and Psychosocial Support
MI: Motivational Interviewing
MNS: Mental, Neurological and Substance Use Disorders
MO: Medical Officer
NHTC: National Health Training Centre
OPD: Out-Patient Department
PHC: Primary Health Care
PHCRD: Primary Health Care Revitalization Division
PHO: Public Health Officer
PMT: Parental Management Training
PRIME: PRogramme for Improving Mental health carE
SN: Staff Nurse
STP: Standard Treatment Protocol
SUD: Substance Use Disorder
SUI: Suicide
TH: Traditional Healer
TPO: Transcultural Psychosocial Organization
TUTH: Tribhuvan University Teaching Hospital
UMN: United Mission to Nepal
WHO: World Health Organization

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Introduction

Global Context

Mental, neurological and substance (MNS) use disorders are one of the serious public health concerns contributing to 14% of the global burden of disease (Prince et al., 2007). Recent World Health Organization (WHO) data revealed that depression and anxiety are the most common mental disorders worldwide affecting about 322 and 264 million people respectively (WHO, 2017). It is estimated that four out of five people with mental health problems in Low and Middle Income Countries (LMIC) receive no effective treatment (Kohn, Saxena, Levav, & Saraceno, 2004). Studies have also documented several adverse consequences of untreated mental illness including pre-mature mortality (Angst, Stassen, Clayton, & Angst, 2002), unemployment (Butterworth, Leach, Pirkis, & Kelaher, 2012), poverty (Lund et al., 2010), homelessness (Folsom et al., 2005), co-morbid substance abuse and addiction (Jane-Llopis & Matytsina, 2006), poor physical health (McWilliams, Cox, & Enns, 2003) and suicide (Hawton & van Heeringen, 2009).

In recent years, several initiatives have been taken globally to reduce the treatment gap for mental health problems. Evidence is accumulating that mental health services can be delivered effectively by primary health care workers through community-based programs and task-sharing approaches (Patel et al., 2010; van Ginneken et al., 2013). Changing the role of specialist mental health workers (i.e. psychiatrists and psychologists) from a predominant focus on service delivery to also designing and managing mental health services, building clinical capacity of the primary healthcare (PHC) workers, and providing supervision and quality assurance of mental health services, could help in scaling up of mental health services in countries like Nepal where specialist mental health services are concentrated in few hospitals located in the big cities (Patel, 2009). The World Health Organization (WHO) launched the mental health Gap Action Programme (mhGAP) for prioritizing mental, neurological and substance use disorders in 2008 which also aims to facilitate the delivery of evidence-based interventions by non-specialized health workers in primary health care settings (WHO., 2008).

Situation of Mental Health in Nepal

In Nepal, there is no nationally representative data on prevalence of mental health problems. However, the available data show that Nepal is not an exception to the global situation. Small scale studies conducted with specific groups of population such as population affected by conflict, refugees, survivors of human trafficking etc. identified a large variation in reported rates of depression, anxiety and post-traumatic stress disorders (Tol et al., 2010). A recent study conducted with population affected by 2015 earthquake found elevated rates of depression (34.3%), anxiety (33.8%), PTSD (5.3%) and alcohol use disorder (20.4%) (Kane et al., 2017). Prevalence rates of depression (11.7% to 27.5%) and anxiety (22.7%