


Health Sector Transition and Recovery Programme

300 Patients Receive Counselling Services From Community Counsellors

August 2016

TPO Nepal
PEACE OF MIND

NHSSP

UKaid
from the British people

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LIST OF ACRONYMS

CIDT	Community Informant Detection Tool
CPSW	community psychosocial worker
CTEVT	Council for Technical Education and Vocational Training
DFID	Department for International Development (UK Aid)
DHO	district health office
DoHS	Department of Health Services
DPHO	district public health office
FCHV	female community health volunteer
GoN	Government of Nepal
GPC	General Principles of Care
IASC	Inter Agency Standing Committee
mhGAP HIG	Mental Health Gap Action Programme- Humanitarian Intervention Guide
MHPSS	mental health and psychosocial support
MoH	Ministry of Health
NGO	non-government organisation
NHSP-2	Nepal Health Sector Programme 2 (2010–2015)
NHSSP	Nepal Health Sector Support Programme
PHCC	primary health care centre
PRIME	Programme for Improving Mental Health Care
PTSD	post-traumatic stress disorder
TPO	Transcultural Psychosocial Organization
VDC	village development committee

1 INTRODUCTION

1.1 Background

Natural disasters such as the 2015 Nepal earthquakes bring the risk of adverse psychosocial and mental health issues including serious post-traumatic psychopathologies. The most common effects include distress and grief, and less frequently but nonetheless commonly, depressive and anxiety disorder. Such events have the potential to create acute short-term impacts on affected populations which, if not addressed, can develop into chronic psychosocial and mental health problems. Disasters and emergencies not only increase rates of mental health problems, but also weaken mental health infrastructure, and make coordination difficult for agencies that provide mental health services.

The rapid emergency psychosocial needs assessment conducted by Transcultural Psychosocial Organization (TPO) Nepal immediately after the second earthquake of 10 May 2015 in some of the affected districts (including Nuwakot, Sindupalchowk and Kavreplanchowk) uncovered psychosocial needs at the individual/family level, the community level, and the institutional response level. Similarly, the needs and resource assessment study conducted by TPO Nepal four months after the first earthquake (25 April 2015) identified several mental health and psychosocial concerns, principally behavioural problems (e.g., increased anger and aggression), cognitive symptoms (e.g. lack of concentration), sleep problems (e.g., sleeping more or less than usual) and somatically expressed psychological problems (e.g., lack of sensation in limbs) among people affected by the earthquakes (TPO Nepal, 2015). The earthquake also exacerbated pre-existing mental health problems of those with ongoing and chronic mental illness. However, mental health and psychosocial support (MHPSS) services are almost non-existent in most of the earthquake affected districts (TPO Nepal 2015). As per the data available, there are 0.06 psychologists and 0.22 psychiatrists per 100,000 population (Luitel et al, 2015) in Nepal, and in the rural areas there is one psychosocial counsellor per 209,000 people (Kohrt et al, 2010).

As a part of the DFID funded Health Sector Transition and Recovery Programme (HSTRP), TPO Nepal is implementing a project to increase access to mental health care in two earthquake affected districts of Ramechhap and Dolakha. The project is funded and managed by the Nepal Health Sector Support Programme (NHSSP) and Options Ltd. The objective of this component of the programme is to provide mental health and psychosocial support services to earthquake affected communities through the integration of mental health and psychosocial support services in the routine health care system based on the mental health Gap Action Program Humanitarian Intervention Guide (mhGAP-HIG). The Inter Agency Standing Committee (IASC) guideline on MHPSS (2007) stresses the importance of psychosocial support in the aftermath of disasters. The mobilization of psychosocial workers is advocated by the IASC guidelines to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency.

Hence, to address the psychosocial counselling needs of the people affected by the earthquakes, TPO Nepal mobilized psychosocial counsellors to each programme district and developed the capacity of community members to provide basic MHPSS services and establish referral mechanisms in communities. The psychosocial counsellors mobilized by TPO Nepal received six-months training (780 hours), which is approved by the Council for Technical Education and

Vocational Training (CTEVT). This training consisted of 40 percent theoretical classes and 60 percent practical classes. The aim for these trained counsellors was to:

- provide supportive and problem solving counselling, individual counselling and psychosocial support in emergency settings; and
- to provide disorder specific therapies such as behaviour activation for people with depressive symptoms, motivational interviewing for people with hazardous and harmful alcohol use, and family interventions for people with psychoses.

1.2 Objectives

Within the overall goal of integrating mental health and psychosocial support services within the existing health care system, the purpose of this assignment was for community counsellors to provide psychosocial counselling to 300 patients.

The specific objectives were as follows:

- To identify community members requiring psychosocial counselling.
- To conduct a thorough assessment and prepare treatment/management plans for people requiring psychosocial counselling/support.
- To conduct counselling sessions as per the needs of clients.
- To coordinate with family members and other available support systems in communities to link clients to other support such as basic needs and legal support.
- To establish a referral mechanism for cases requiring specific psychosocial counselling.
- To terminate counselling sessions of recovering cases, and/or refer cases for specialized care if needed.
- To support and motivate people on psychotropic medication to adhere to their treatment.

2 SERVICE DELIVERY

2.1 Mobilisation of Counsellors

In total, eight psychosocial counsellors were mobilized in the project, four each in Ramechhap and Dolakha districts[1]. The counsellors were stationed in different clusters based on the number of cases and services accessible to the maximum number of VDCs and health facilities (Table 1).

Table 1: Work stations of the counsellors

Ramechhap	Dolakha
Manthali Municipality	Bimeshwor Municipality
Ramechhap Municipality	Jiri Municipality
Preeti VDC	Singati VDC
Doramba VDC	Bhirkot VDC

The counsellors have seen most of the cases in a community setting; however, some were stationed at health facilities including in Charikot Hospital and Jiri Hospital in Dolakha and Manthali primary health care centre (PHCC) and Ramechhap District Hospital in Ramechhap.

There were four main ways by which counsellors came into contact with clients:

I. referrals from health facilities;
II. case identification and referral from community members particularly during community orientation and sensitization programmes;
III. referral from mental health case identification and referral-trained female community volunteers (FCHVs); and
IV. referral of difficult cases from community psychosocial workers(CPSWs).

Psychosocial counsellor counselling a women aged 19 at Charikot PHCC

Most clients received counselling services in their homes or rooms; however, counselling sessions were also held in the open after ensuring the confidentiality and comfort of clients.

[1] Additional counsellors, one in each, were mobilized in Kavre and Nuwakot districts using non-DFID resources

2.2 Number who Received Counselling Services

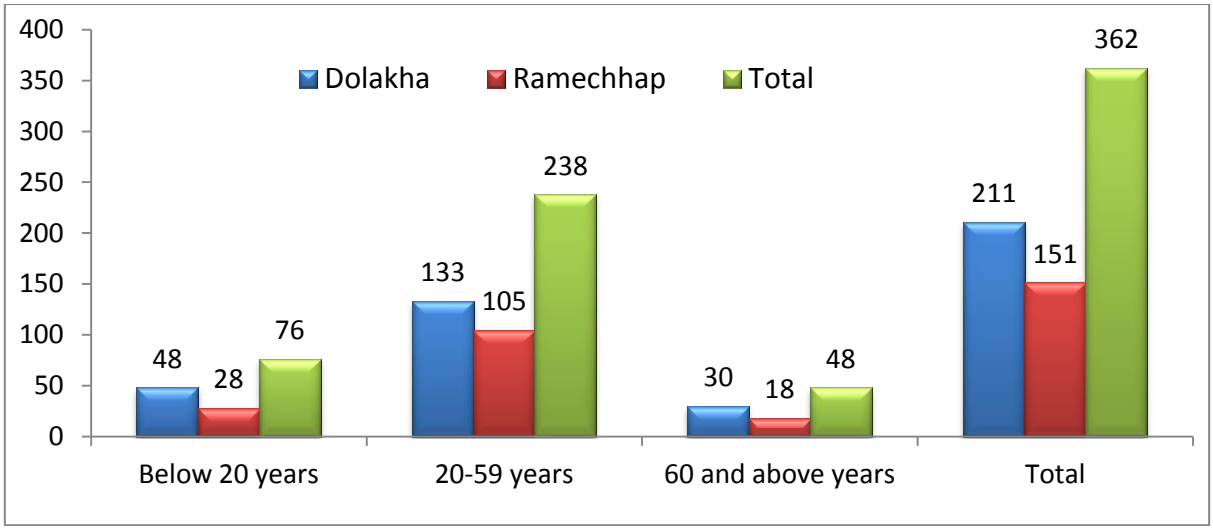
A total of 362 people received counselling services in Ramechhap (151) and Dolakha (211) districts with counselling sessions for a number of clients still ongoing[2]. This is 21% higher than targeted.

2.3 Socio-demographic Characteristics of Clients

a. Age

Figure 1 shows that the largest number of people receiving counselling services were in the 20 to 59 years age group followed by those below 20 years and those above 60 years. The trend is similar in both districts. Percentage-wise representation shows 65.8% of clients were aged 20–59 years, 21% were below 20 and 13.3% were 60 and above.

Figure 1: Distribution of beneficiaries by age (Number)

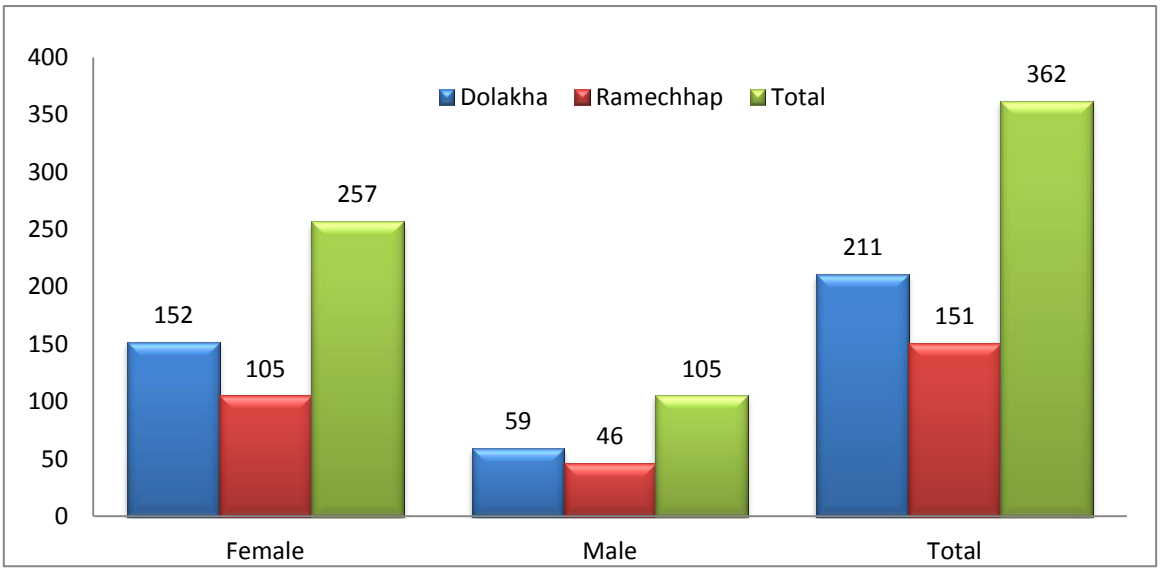


b. Sex

As seen in Figure 2, the majority of people receiving counselling services were female in both districts. Almost three-quarters (71%) of cases was female and 29% male. A possible explanation for this could be the out-migration of males to foreign countries for employment and females being more inclined to discuss their problems.

[2] Similarly clients in the non-DFID funded districts of Kavre (31) and Nuwakot (88) received counselling.

Figure 2: Distribution of beneficiaries by sex



c. Caste and ethnicity

This report presents data by the three broad categories of Brahmin/Chhetri, Janajati and Dalit. It is noted that the caste/ethnicity distribution is different in the two districts. In Dolakha, the majority of clients accessing services were Brahmin/Chhetri followed by Janajatis and Dalits, whereas in Ramechhap the majority were Janajatis (Table 2). In both districts, significantly more Brahmin/Chhetris and Janajatis used services than their populations as a whole would predict, while the reverse was true of Dalits in Ramechhap but not in Dolakha. This raises equity concerns on the abilities of the poor and socially marginalised to access services in these areas.

Table 2: Distribution of clients by ethnicity

Caste/Ethnicity	Dolakha	% of total	% in district	Ramechhap	% of total	% in district	Total
Brahmin/Chhetri	130	62	43	60	40	32	190
Janajati	59	28	47	62	41	58	121
Dalit	22	10	9	29	19	9	51
Grand Total	211			151			362

Source of district population profiles CBS 2011

Types of Client Problems

Counsellors do not provide mental health diagnosis but provide services based on the symptoms presented. Of the total, the majority of people receiving counselling services were experiencing fear and sadness and presented symptoms of depression and post-traumatic disorders. One-third of clients had sleep disturbances. Other reported problems included headache, worry, stress, suicidal thoughts, aggression and anxiety.

Of the 362 who received counselling services from community counsellors, 143 (39.5%) were simultaneously receiving services from a health facility. Among these cases, the majority had a major depressive disorder, followed by anxiety and psychosis (Table 3).

Table 3: Referred cases as diagnosed in health facilities

Disorder (diagnosed by health workers)	Dolakha	Ramechhap	Total
Depression	15	28	43
Anxiety	8	12	20
Psychosis	12	9	21
Epilepsy	6	9	15
Alcohol Use Disorder (AUD)	7	8	15
Conversion disorder	9	4	13
Others (insomnia, PTSD, suicide, intellectual disability)	13	3	16
Total	70	73	143

2.4 Sources of Referrals

Most of the clients were referred by trained health workers (136) and community psychosocial workers (112) (Table 4). Other sources of referral were FCHVs, INGOs, NGOs and family members. Twenty one clients approached the counsellors themselves.

Table 4: Sources of referral of clients

Referred by	Dolakha	Ramechhap	Total
Health worker	83	53	136
Community psychosocial worker	61	51	112
Female community health worker	21	24	45
INGOs/NGOs	24	14	38
Self	18	3	21
Family member	-	2	2
Other	4	4	8
Total	211	151	362

2.5 Types of Counselling Services Provided

Psychosocial counselling services were mostly provided to patients individually, but in some cases family members were also involved. The main purpose of engaging family members is to 'psychoeducate' them on the patient's condition and the family's roles and responsibilities in adhering to treatment. In total, 40 families received family counselling in Dolakha and 17 families in Ramechhap. Table 5 shows the total number of people receiving different levels of counselling services.

Table 5: Distribution of cases by types of counselling services provided

Type of intervention	Dolakha	Ramechhap	Total
Individual	171	128	299
Family	40	17	57
Both (individual/family)	0	6	6
Total	211	151	362

2.6 Number of Sessions and Outcome

Table 6 shows the number of sessions taken by clients with counsellors. Most clients received one individual counselling session. This could be because:

- most clients simply wanted medications rather than counselling;
- geographical challenges of making frequent visits;
- the general unavailability of clients during home visits due to them being busy with work.

Additionally, since the service is ongoing in most cases, many scheduled follow up sessions have yet to be conducted.

Table 6: Number of sessions conducted per case

No. of sessions	Dolakha	Ramechhap	Total
1 only	99	122	221
2 to 3	92	20	112
4 to 5	11	9	20
More than 5	9	0	9
Total	211	151	362

Out of 362 people who have received counselling services, 35 cases were terminated after improvements in symptoms of which 21 were from Dolakha and 14 from Ramechhap. Five people in Dolakha and 27 in Ramechhap were referred to health facilities within their districts for pharmacological management after receiving counselling. Similarly, six cases in Dolakha were referred to the psychiatrist from TPO Nepal while one patient was referred to Dolakha one stop crisis management centre (OCMC).

Table 7: Number of cases referred to a health facility, psychiatric care and an OCMC

Referred to	Dolakha	Ramechhap	Total
Health facility	5	27	32
Psychiatric care	6	-	6
OCMC	1	-	1
Total	12	27	39

2.8 Trends of psychosocial problems before and after earthquake

Table 8 shows that the number of clients with psychosocial problems resulting directly from the earthquake was relatively low (56). Most clients (306) had experienced mental health problems before the earthquake but that the earthquakes had exacerbated them.

Table 8: Distribution of clients seen pre and post-earthquake

Cause	Dolakha	Ramechhap	Total
Resulting from the earthquake	47	9	56
Pre-existing the earthquake	164	142	306
Grand Total	211	151	362

2.9 A Successful Case Study

Thirty year-old Sita *(name changed*) from Ramechhap district, was forced to marry by her family. A few years after her marriage, her husband married another woman and took Sita's son without her consent. She went through stress when left empty-handed, and started showing unusual behaviour like self-talking, crying, shouting at people for no apparent reason, and roaming around the village. Her family were startled by her behaviour and had no other option but to lock her up in a room. She was locked up for a year where she ate and defecated in that one room.

It was after the massive earthquakes of May and April 2015 while TPO Nepal were conducting a community sensitization programme that her family member came to know about the free mental health services being provided at local health posts. When her family brought her to the health post, she looked unkempt and seemed aggressive and violent. The health workers conducted a detailed assessment with her family members and identified some of her problems such as a weak body, sleep disturbance, dysfunctional mental orientation and aggression and disruptive relationship with her family and community. The family was provided with psychoeducation about her condition and that the problem was treatable if provided with the right treatment. The family was also encouraged to treat Sita with proper care and affection. After psychoeducation, Sita was put on medication and given family counselling. In total, four counselling sessions were conducted with Sita and her family.

The family seemed to be taking proper care of her in terms of ensuring adherence to treatment. Some positive changes were noticed over time. Sita seemed to be carefully maintaining her hygiene. She also started helping out with household chores and stepping out of the house to work in the fields.

She is continually taking her medication and when it finishes, she visits the health post by herself to get more medicine. She is now able to communicate her emotions and has also re-established relationships with others. She is grateful for the services received and wishes to continue receiving them as long as required. In the future, she expects to engage in some skill-based training.

3 CHALLENGES

Many challenges were faced during the delivery of counselling services and the implementation of the project as follows:

1 Stigma around mental illness and psychosocial problems was still prevalent even after the community awareness programmes were run. Community members have the belief that counselling alone cannot help people with mental health problems and preferred to seek services from traditional healers rather than counsellors. One counsellor from Tokarpur VDC of Ramechhap district said:

"A 23 year old woman had epilepsy for three years. When the counsellor provided information about the illness, the family members were not ready to listen and kept on going for follow ups with traditional healers".

2 Another challenge was that quite a few clients and their families were not interested in follow up after attending one session. When the counsellors returned on home visits many clients were not available which restricted the number of sessions.

3 Due to the geographical challenges of reaching many clients, more frequent sessions were difficult and prior information was not possible to organise appointments via phone.

4 One counsellor had to look after many VDCs and the travel between two VDCs took hours. For example, a counsellor posted in Doramba VDC had to walk 10 hours to reach Lakhanpur for follow up.

5 There were delays in the implementation of the project at the beginning that led to delays in service delivery

6 Due to the uncertainty of project continuation, some counsellors left the job and new ones had to be hired.

4 PLANS VS ACHIEVEMENTS

As shown in Table 9, planned activities have been achieved. The counsellors were mobilized in four clusters in both districts. Counselling services were provided to more than the target population of 300 people (N=362) in two earthquake affected districts. The socio-demographic profile, and assessments of needs, services provided, referrals and numbers of sessions have been completed. The counsellors used four formats (intake form, session report form, termination form and referral form — see annexes) to document the counselling process.

Table 9: Plans vs achievements

Planned	Achieved
Mobilization of counsellors	Done
Counselling services given to 300 people	Done (achieved 362)
Report on patient needs, treatment, referral and follow up	Done

List of References

Luitel, N. P., Jordans, M. J., Adhikari, A., Upadhaya, N., Hanlon, C., Lund, C., and Komproe, I. H. (2015). Mental health care in Nepal: current situation and challenges for development of a district mental health care plan. *Conflict and health*, 9(1), 1.

Kohrt, B. A., Perera, E., Jordans, M. J., Koirala, S., Karki, R., Shrestha, B., and Upadhaya, N. (2010). *Psychosocial support model for children associated with armed forces and armed groups in Nepal.*Kathmandu, Nepal: Transcultural Psychosocial Organization-Nepal/UNICEF.

World Health Organization. (2015). *mhGAP Humanitarian Intervention Guide (mhGAP-HIG): clinical management of mental, neurological and substance use conditions in humanitarian emergencies.* World Health Organization.

Inter-Agency Standing Committee (2007). *Guidelines for Mental Health and Psychosocial Support in Emergency Settings*. Geneva.

Websites:

- http://www.moha.gov.np/
- http://www.ctevt.org.np/

ANNEX 1: Patient Intake Form

Transcultural Psychosocial Organization (TPO) Nepal
Individual Counselling Form

INSTRUCTION: This form should be filled up by the counsellor/psychologist for every person that enters the Minimal Psychosocial Care Package interventions.

1. Client Details

A. Counsellor: _____
B. Name: _____
C. Age: _____
D. Gender: _____
E. Ethnicity: _____
F. Religion: _____
G. Address _____

2. Identified problems and reasons for intake:

Psychosocial Problem	**Put tick mark if applicable**	**Severity** **1- Mild** **2- Somewhat severe** **3- Severe** **4- Very severe**
A. Behavioural problems		
A1 Stealing, running away (conduct disorder)		
A2 Hyperactivity		
A3 Aggression		
A4 Alcohol/ substance use		
A5 Bedwetting/soiling (*enuresis*)		
A7 Others (specify)		
B. Developmental problems		
B1 Mental retardation		
B2 Learning difficulties		
B3 Backwardness		
B4 Other (specify)		
C. Depressive problems		
C1 Sadness		
C2 Concentration problems		
C3 Suicidal feelings/ thoughts		
C4 Guilt/ blaming oneself		
C5 Sleeping disturbances		
C6 Loss of appetite/ energy		
C7 Other (specify)		

D. Anxiety/ Stress complaints		
D1 Fears		
D2 Worry		
D3 Nervousness/ sweating, trembling, heart pounding		
D4 Post traumatic stress reactions		
D5 Separation anxiety		
D6 Fear of death		
D7 Others (specify)		
E. Social complaints		
E1 Family conflict		
E2 Social withdrawal		
E3 Discrimination (specify)		
E4 Neglect		
E5 Victims of violence		
E6 Other (specify)		
F. Physical problems		
F1 Headache		
F2 Stomach ache		
F3 HIV/AIDS related		
F4 Fits (non-epileptic)		
F5 Epileptic		
F6 Gynaecology and reproductive health problems		
F7 Abortion		
F8 Miscarriage		
F9 Pregnancy		
F10 STI		
F11 Uterus Prolapse		
F12 Irregular menstruation		
F13 Lower abdominal pain		
F14 White water discharge		
F15 Wart		
F16 Others (specify)		
G. Severe Mental health problems		
G1 Psychotic		
G2 PTSD		
G2 Others (specify)		
H. Causes/traumatic events		
H1 Witness to trauma		
H2 Sexual abuse		
H3 Scolding by abusing words		
H4 Rape case		
H5 Group Rape		
H6 Touching sensitive organs		
H7 Others (specify)		
I. Physical Abuse		
I1 Beatings		
I2 Cigarette burn		
I3 Pinching		

I4 Alcohol and substance abuse		
I5 Imprison in room		
I6 Others (specify)		
I7 Physical Torture		
I8 Beatings		
I9 Piercing in sensitive organs		
I10 Torture with electric current		
I11 Pulling hair		
I12 Others (specify)		
J Mental Torture		
J1 Taken into custody		
J2 Scolding		
J3 Abuse words		
J4 Not allowed to meet anyone		
J5 Imprison in dark room		
J6 Threats		
J7 Others (specify)		
J8 Displacement		
J9 Domestic violence		
J10 Unsatisfied due to poverty		
J11 Others (specify)		

3. Reasons of intake and sources of client referral

Referred from CBI ……1
CBI drop out ……..2
Referred by community……..3
Referred by teachers……4
Referred by CPSW……..5
Sent by other organizations……..6
Others (specify)……..7

ANNEX 2: Session Report Form

Transcultural Psychosocial Organization (TPO) Nepal

Session Report Form

1. Client details:

Name: ..... Age/Sex:.....

Contact No.:..... Session No.....

Time:..... Time Duration.....

2. Current complaints:

3. Words used to express problems:

4. Observations:

5. Support provided:

6. Outcomes:

7. Clients understanding about the problem:

8. Recommendation by counsellors:

9. Plan:

Psychosocial Counsellor's Name: District:

Signature: Date:

ANNEX 3: Termination Form

Transcultural Psychosocial Organization (TPO) Nepal

Counseling Termination Form

Client's name : ..... Date:.....

Address :..... Sex:.....

Age: ..... Occupation:.....

Marital Status :.....

No of sessions:.....

Education Level:.....

Case Summary/Background:

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.....

Identified Psychosocial Problems:

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Counselling Intervention:

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Observed impact of the intervention(s):

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……

……

……

(Causes of session Termination):

Because of Improvement	1
Because of no improvement	2
Referred to other places	3
Client's unsatisfaction in counseling	4
Others (Please mention) ……	

Further recommendation(s):

……

……

……

……

……

Name of Psychosocial Counsellor

……

Signature**: ……** Date: **……**

ANNEX 4: Referral Form

Transcultural Psychosocial Organization (TPO) Nepal
Referral Form

1. Client details:

Name: ..... Age/Sex:.....
Marital Status:..... Education:.....
Contact No.:..... Parent's Name:.....
Contact No.....
Guardian Name, if different than parents.....

2. Background of the client:

3. Support provided:

4. Impact on client:

5. Client's expectations:

6. Reason for referral and recommendation:

Referred agency.....
Referred by (Name of counsellors):.....
District:.....
Date:.....
Signature:.....