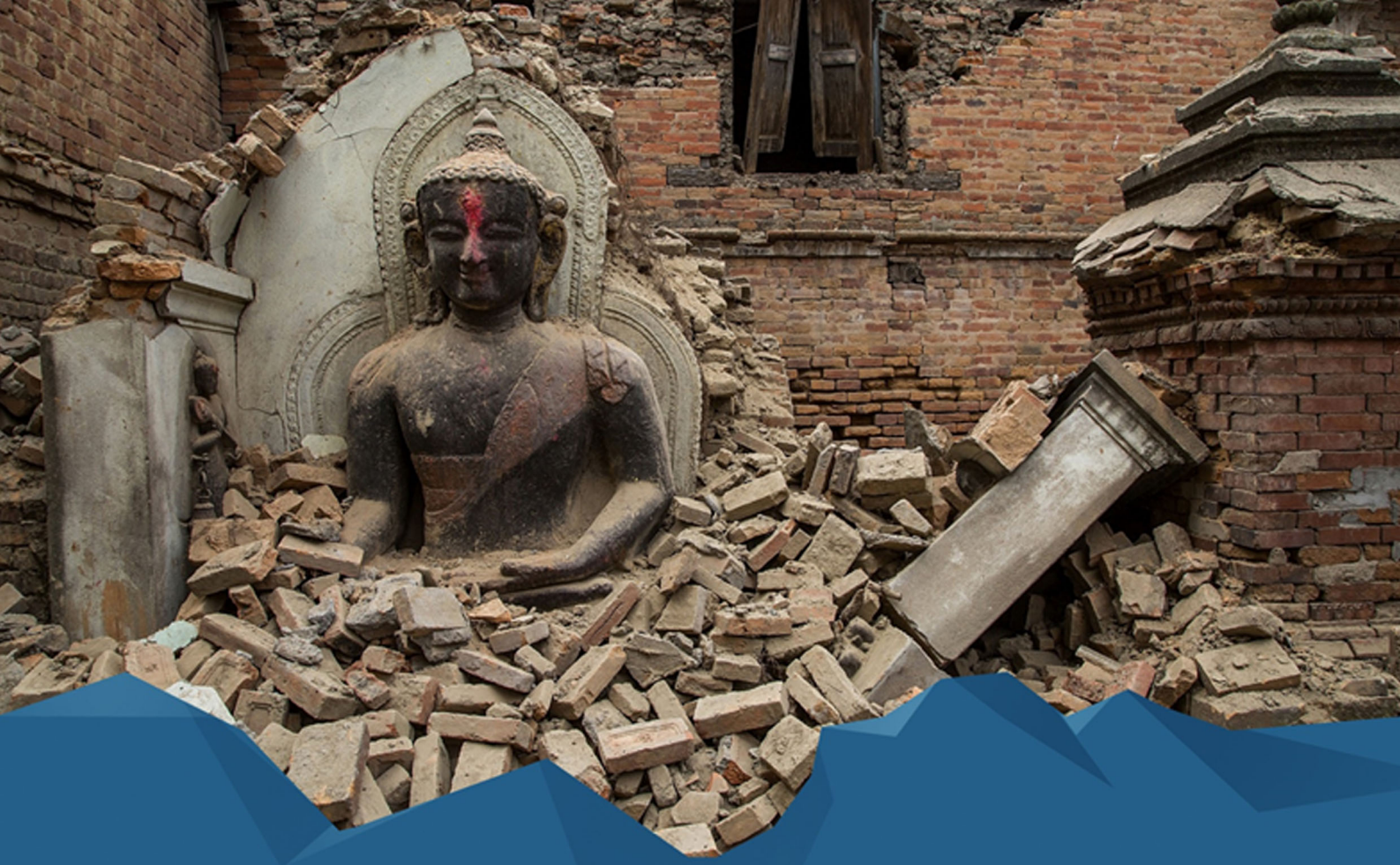

Health Sector Transition and Recovery Programme

50 additional prescribers trained on mhGAP-HIG

Transcultural Psychosocial Organisation

July 2016

TPO Nepal
PEACE OF MIND

NHSSP

UKaid
from the British people

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50PRESCRIBERS (25 IN EACH DISTRICT) TRAINED ON MHGAP-HIG

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LIST OF ACRONYMS

AHW	Auxiliary Health Worker
DFID	Department for International Development (UK Aid)
DHO	District Health Office
ENACT	Enhancing Assessment of Common Therapeutic Factors
HA	Health Assistant
HF	Health Facility
HSTRP	Health Sector Transition and Recovery Programme
mhGAP-HIG	Mental Health GAP Humanitarian Intervention Guide
NGO	Non-Government Organization
NHSSP	Nepal Health Sector Support Programme
OPD	Outpatient Department
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PTSD	Post-Traumatic Stress Disorder
TPO	Transcultural Psychosocial Organization
PRIME	Programme for Improving Mental Health Care

1. BACKGROUND AND OBJECTIVES

1.1 Background

Under the Health Sector Recovery and Transition Programme (HSTRP), TPO Nepal has been implementing a project supported by NHSSP/Options to increase access to mental health care in four earthquake affected districts, Ramechhap, Dolakha, Kavre and Nuwakot. The aim of this project is to integrate mental health and psychosocial support services into the existing health care system to address the mental health and psychosocial support needs of affected communities.

Key activities under this program include capacity building of health workers on mental health and psychosocial support, clinical supervision through monthly case conferences, service delivery (both pharmacological and psychosocial support), community detection and referral, and specialized care through establishing referral systems.

In the post-earthquake situation, one option to address the mental health and psychosocial support needs of affected populations is to build the capacity of primary health care workers to integrate these services in the routine health care system. In this respect, we have trained 141 prescribers (71 in Ramechhap and 70 in Dolakha) on the mental health Gap Action Programme-Humanitarian Intervention Guide (mhGAP-HIG). In addition, we have provided continuous clinical supervision and support through monthly case conferences with trained psychiatrists. To date, more than 1500 people with mental health and psychosocial problems in Ramechhap and Dolakha districts have received mental health services from these trained health workers.

While initially, this payment deliverable (TPO PD-8) was concerned with 3-days refresher training for trained prescribers, changes were made following a strong recommendation from the district health office (DHO) in both the districts. According to the DHOs, the trained heath workers had improved their skills as a result of monthly supervision such that rather than providing them with refresher training, it would be preferable if new health workers (prescribers) received eight days training on the mhGAP-HIG module.

Altogether 22 health facilities were found to have no human resources trained in mental health. 18 trained prescribers (8 in Dolakha and 10 in Ramechhap) had been transferred to other districts while prescribers from four facilities (1 in Dolakha and 3 in Ramechhap) had not previously attended training due to their busy schedules. For this reason, all incumbent prescribers were trained. Additionally, prescribers from health facilities with high caseloads were trained as per the DHOs' recommendation. In total, 53 prescribers (24 from Ramechhap and 29 from Dolakha) from 28 health facilities participated in the training.

1.2 Objectives

The overall purpose of this assignment was to train additional prescribers (N=53) from both Dolakha and Ramechhap districts to broaden the mental health and psychosocial support services in affected communities.

The specific objectives were:

- to build the capacity of additional prescribers to identify and manage mental health problems;
- to enable additional prescribers to provide basic psychosocial support, including psycho-education;
- to build the capacity of health workers to refer cases requiring specialist care.

2. METHODOLOGY

2.1 Preparation of Training Materials and Reading Materials

We used the same training manual and materials used in previous training sessions. We adapted the training manual developed by PRIME (Programme for Improving Mental Health Care) in the post-earthquake setting of Nepal. The revised manual followed the mhGAP-HIG guide. We also provided printed copies of the manual to the trained health workers.

2.2 Selection of Health Workers

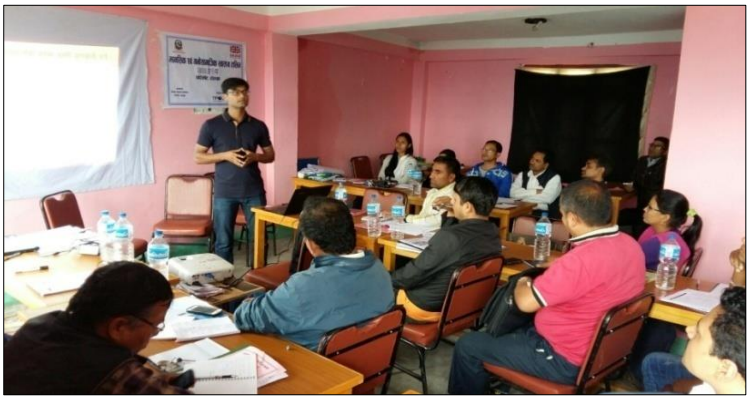
Participants for the training were selected by the DHOs in collaboration with TPO Nepal district teams. The DHOs from both districts were also involved in coordination of the training, especially in selecting training venues, finalizing training dates and inviting participants.

The health workers selected from the health facilities were: a) mental health trained prescribers who had not previously received training; b) previously trained health workers transferred to these health facilities or other places; c) facilities where not even one prescriber had attended mental health training, d) where the client flow and need for trained human resource was relatively high. In addition, one prescriber in Ramechhap district was selected from the community health facility (non-governmental).

Altogether, 29 prescribers from 26 (i.e. 1 district hospital, 1 PHCC, and 23 health posts) health facilities and the DHO received the training in Dolakha. In Ramechhap, 24 prescribers from 22 health facilities and the DHO received the training. Not all prescribers in the respective health facilities could be included in the training due to budget limitations and time constraints.

The prescribers trained were medical officers, health assistants (HA) and auxiliary health workers (AHWs). In Dolakha, 2 were medical officers, and 27 were HAs, Sr. AHW/AHW and others; whereas in Ramechhap 4 trainees were medical officers and 20 were HAs, Sr. AHW/AHW and others.

Fig 1: Psychiatrist providing training in Dolakha



2.3 Training Methods

Several methods and techniques were used in the training including: power point presentations and mini-lectures to provide in-depth information on mental health problems and their symptoms; group work and discussions to encourage participants to engage and gain practical knowledge and experience; role plays were enacted and videos (with Nepali subtitle) shown to teach interviewing and history-taking skills. Further, videos of cases of conversion disorder and epilepsy were shown to demarcate differences between the two.

In addition, case stories drawn from the clinical experiences of the psychiatrists were shared. Other modalities such as playing games, mini assessments, and brain storming were also used. Further, patients with mental health problems were invited to the training where psychiatrists (trainer) demonstrated history taking and other mental health examinations. In total, 5 (4 in Dolakha and 1 in Ramechhap) such cases were discussed during training.

Fig 2: Practical training session

3. ASSESSMENT OF TRAINING OUTCOMES

To evaluate the effectiveness of the training, several assessments were carried out before and after training in three broad areas: (1) knowledge on psychosocial and mental health; (2) attitudes and perceptions on mental illness - especially on the stigma associated with mental health - and 3) clinical competencies of training health workers to provide psychosocial support.

3.1 Assessment on Mental Health Knowledge

A pre- and post-test was conducted to assess prescribers' knowledge and attitudes towards mental health and psychosocial issues prior to and following the training using the same instruments. The instruments have 40 items (Annex 3), the first 20 of which assess general knowledge on mental health and psychosocial issues, and the remaining 20 assess health workers' knowledge and attitudes on mhGAP. Comparing participants' post-test scores with pre-test scores enabled us to assess whether or not the training had succeeded in increasing participants' knowledge of the training content.

3.2 Therapeutic Competency Assessment

As a part of the post-test, ENACT (Enhancing Assessment of Common Therapeutic factors) was conducted to assess the prescribers' skills in psychological treatment. This is a rating scale that helps assess therapists' competencies, where participant health workers perform the role play of service providers and the trainers rate the participants' cognitive ability and communication skills based on observation. The scale has 18 items for expert rating and 11 items for peer and self-rating.

3.3 Clinical competencies in providing psychosocial support

The areas for ongoing assessment involved phone calls received by the psychiatrist under phone supervision, monthly supervision by psychiatrists, 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.

4. PLANS FOR SUPERVISION

As indicated in the project proposal, three types of supervision will be provided to the non-prescribers going forward:

(1) phone supervision: trained health workers can directly contact psychiatrists if they need support to diagnose and manage mental health problems;

(2) psychiatrist conferences whereby trained health workers are invited to present difficult cases (i.e. clients in person or clients' case notes) in one health facility, where the cases are discussed and other queries raised with the psychiatrists, and

(3) on-the-job supervision where psychiatrists visit health facilities and provide individual support to health workers. Psychiatrist case conferences and on-the-job supervision are being carried out monthly while phone supervision is provided as per need.

In addition, psychosocial counsellors provide supervision on psychosocial aspects of the services as per the need.

5. PLANS VS ACHIEVEMENTS

Planned	Achieved
Selection of the health workers	Done
50 prescribers trained in mhGAP HIG	Done

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ANNEX 1: TRAINING CONTENT

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

ANNEX 2: TRAINING EVALUATION FORMS

PART 1

1. How likely it is for people with a severe mental illness to recover enough to have a good life?

All mental health patients can return to their normal life situation after the recovery……1
Most of the mental health patients are likely return to their normal life situation after the recovery.2
Only some of the mental health patients are likely return to their normal life situation after the recovery……3
No mental health patients can return to their normal life situation after the recovery……4

2. If you had a mental illness, would you not admit this to your friends because you would fear being treated differently?

I wouldn't fear to admit this to my friend……1
I would only admit it to few of my close friends……2
I would only admit it to my best friend……3
I wouldn't admit it to anyone……4

3. How often people with a severe mental illness are dangerous than not?

They are less dangerous than normal people……1
They are as dangerous as normal people……2
Some of them are more dangerous than normal people……3
All people with mental illness are dangerous……4

4. If you had a mental illness, would you not admit this to your colleagues because you would fear being treated differently?

I wouldn't fear to admit this to my colleague……1
I would only admit it to few of my close colleague……2
I would only admit it to my best colleague……3
I wouldn't admit it to anyone……4

5. How likely it is for a health/social care professional in the area of mental health is not get respected like otherhealth/social care professional?

People give more respect to health workers treating mental illness than other health workers……1
People respect the health workers treating mental illness as same as the other health workers……2
People don't really respect the health workers treating mental illness as same as the other health workers……3
People don't at all respect health workers treating mental illness as same as the other health workers……4

6. If a senior colleague instructed you to treat people with a mental illness in a disrespectful manner, would you follow their instructions?

I would follow their instructions……1
I would probably follow their instructions……2

I might not follow their instructions……3
I will not follow their instructions……4

7. How important it is that any health/social care professional supporting a person with a mental illness also ensures that their physical healthis assessed?

It is very important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed……1
It is mostly important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed……2
Sometimes it might be important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed……3
It is not important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed because they can be referred to specialized mental health care……4

8. What do you think about General practitioners completing a thorough assessment for people with psychiatric symptoms?

They should always complete a thorough assessment for people with psychiatric symptoms……1
They should most of the time complete a thorough assessment for people with psychiatric symptoms……2
They should sometimes complete a thorough assessment for people with psychiatric symptoms..3
They should not be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist……4

9. How often in your work during last year did you use the words "Crazy", "Mad" to refer to a person who has a mental illness?

I used it every day……1
I used it sometimes……2
I used it very less number of times……3
I never used that sort of words……4

10. If a co-worker in your office told you they had a mental illness, would you still want to work with them?

I would want to work with them like I did before……1
I might to some extent want to work with them……2
I might not want to work with them……3
I would not at all want to work with them……4

PART 2

Please go through the questions given below and out of the four answers given for each question circle the one which you feel is right.

1. What is psychosocial problem?

Problems observed in society……1
Mental problem……2
Problem by birth ……3
Problem of imbalance between the individual and society……4

2. What aspect of the individual does the psychosocial problem affect?

Heart-mind……1
Body……2
Relationships……3
All of the above……4

3. In order to be a good caregiver for service user

Economic support should be given……1
Treated with a trust worthy and positive behavior……2
Should visit their homes and aid in the household chores, as per need……3
Should flow with their emotions……4

4. Which among the following does help the most in gaining confidence?

Questioning much about the incident/events, listening to their response and provide suggestions based on that……1
Giving information, taking permission, respecting, letting service users take decision on their own……2
Helping with their works, giving economic aid, supporting by making decisions for them……3
Focusing on teaching moral values by preaching them, finding out their faults……4

5. What all should be done to expand relations and emotional support?

Economically supporting the individual, giving them loans……1
Visiting the individuals' home and helping them in their works, doing their agricultural works……2
Taking permission from the individual, giving information, and behaving them with respect……3
Individual's problems should be discussed in different places……4

6. Which one of the following does not fall under the basic communication skills?

Provide open questions……1
Reflection of feelings……2
Sympathizing ……3
Summarizing……4

7. What is active listening?

Listening to the service user and giving no reaction……1
Listening to the service user and reacting with only some words ……2
Observing the service user, listening carefully, and giving necessary reactions……3
Asking them many questions and answering gradually……4

8. Which of the sayings below reflect empathy?

How sad! So, this has happened to you……1
I exactly understand what has happened to you……2
I can understand that you have been in difficulty because of that……3
You don't need to worry, everything will be fine……4

9. How can we give psychological first aid?

Counseling……1
Giving first aid and sympathizing……2
Giving emotional support without asking any unnecessary questions on the event/incident……3
I don't know……4

10. Match the following:

a.	Basic security and support	Counseling
b.	Community and family support	Mother Group
c.	Focused but unspecialized support	Food respective to culture
d.	Specialized support	Psychotherapy

2. **Questions adapted from mhGAP**

A. Put X in the correct column.	True	False
A private space for mental health evaluations is not important. Patients with mental health problems can be asked any questions regarding their personal lives, symptoms, and safety risk in a consultation room with lots of other people around.		
Asking about suicide will cause the person to attempt suicide		
When a person is stressed due to adverse or extreme events, providing social support does not help. The person should always be told to stay alone away from other people.		
Most people who experience an earthquake or other traumatic events will have mental disorders that last their entire lives.		
People with mental health problems usually cannot make decisions concerning their health		
During a seizure, put a spoon into the mouth to prevent biting the tongue.		
Drinking too much alcohol is a mental illness that can be treated through counseling		
Medications are always the most effective treatment for mental health problems.		
The best place for a person with suicidal thoughts to receive treatment is in a jail		
If a person who drinks a lot of alcohol has a seizure, he/she needs to go to a hospital immediately		

B. Put **circle** the correct answer. There is only one correct answer for each question.

10. A 22 years old woman tells you that she has been having problems sleeping and nightmares since the earthquake. You should:

Tell her that she has depression, which is a mental illness that always requires medicine……1
Tell her that she has Posttraumatic Stress Disorder and start alprazolam at a dose of 0.25mg every night at bedtime……..2
Ask the patient to tell you more about what has been bothering her, and evaluate her for symptoms of different types of mental illness……..3
Write a prescription for amitriptyline with a starting dose of 150mg to take twice daily (morning and bedtime)…… ……..4

11. If someone is experiencing harmful use of alcohol or drugs, you should:

Tell them that only bad people who don't care about their families drink alcohol……1
Only tell them about the physical health problems caused by alcohol (liver damage, bleeding in the stomach, and damage to the brain) but not discuss any social problems from alcohol…….2
Start a brief motivational conversation, which includes a discussion of their personal perceived benefits of drinking and harms of drinking……..3
Start amitriptyline 25mg daily because depression is always present when someone uses alcohol or drugs……..4

12. Which of the following messages should be given to a person with depression?

Stop all physical activity and stay in bed all day……..1
Try to participate in social activities with friends and family as much as possible……2

Take vitamin injections every week……3
Start fluoxetine 10mg once daily then stop the medication immediately when you feel better……..4

13. Concerning medication for depression, which of the following is correct?

Children should always be given medicine for depression……..1
If a person starts antidepressant medicine, it usually starts working in 1 to 2 hours……..2
Patients taking medicine for depression will never attempt suicide when they are taking medicine…3
A psychiatrist must always be consulted before starting psychiatric medication on a child……..4

14. If a patient has symptoms of grief but does not meet any other psychiatric diagnosis, you should

Tell him/her to take alprazolam 0.5mg whenever they feel worries or anxiety…….1
Tell the person they should not cry because this will make the grief worse……2
Help the patient to improve social support from family members, friends, and community groups……3
Tell the patient that physical symptoms during grief (headache, numbness/tingling, stomach pains) are always a sign of serious medical disease such as cancer or diabetes……4

15. Concerning the management of acute psychosis

An intramuscular injection of haloperidol is always required……1
Verbal de-escalation (talking to calm someone down) should only be used after medication is given.2
The person should be restrained (e.g. chained or tied up) to prevent harming other people……3
If intramuscular injections (e.g., haloperidol) are given, the patient should be monitored for at least 24 hours for signs of dystonic reactions (e.g., difficulty swallowing, difficulty turning one's neck, or moving limbs)……4

16. Concerning seizures (falling spells), which of the following is correct

Once a medication for epilepsy is started, it can be stopped at any time and seizures will not come back……..1
Some falling spells may be caused problems in the brain that require ongoing medicine, but other falling spells may be caused by stress (e.g., non-epileptic seizures). Both require lifelong anticonvulsant medication……..2
Phenobarbitol and carbamazepine can both cause a life-threatening rash in which large areas of skin can be lost. Patient and families should be told to contact doctors immediately if a new rash appears when taking these medicines……3
Once the diagnosis of epilepsy is made in a woman with epilepsy, she should not marry or have children……4

17. After a suicide attempt

Leave the person alone and stop all visits from family and friends……1
Send the patient immediately to jail……2
Talk to the family to remove means of self-harm from the house (e.g., remove plant pesticide, rat poison, and sharp knives)……3
Give the patient a prescription for amitriptyline 25mg daily ……4

18. Which of the following treatments is NOT an evidence-supported treatment for PTSD

Cognitive behaviour therapy (a type of counseling) ……1
Fluoxetine or other SSRIs……2
Alprazolam or other benzodiazepines……3
Strengthening social support through involvement of friends and family in care and recovery……4

19. If a patient has depression with somatic complaints (e.g., headaches, stomachaches, numbness/tingling, or irregular periods for women) what should be done

Tell the patient and family that these are all caused by stress and instruct them to stop worrying about them……..1

Evaluate and rule out differential diagnosis such as anemia, parasites, vitamin deficiency, and high or low blood sugar……2

Start iron supplements, vitamin injections, and paracetamol when starting amitriptyline or fluoxetine……3

Explain to the family that the patient is faking these symptoms and that the patient should be ignored whenever he/she is talking about these complaints……4

ENACT-Expert Version

Date ___ ___ / ___ ___ / ___ ___ ___ ___ **Check One:** ☐ **Pre-Test** ☐ **Post-Test** ☐ **Supervision**
Day Month Year

Name: _____ Age: _____ Gender: M/F Health profession: _____

Person completing form: _____

Location:_____

1. NON-VERBAL COMMUNICATION & ACTIVE LISTENING: EYE CONTACT, EXPRESSION, BODY LANGUAGE, & GESTURES		
1	**NEED IMPROVEMENT**	= does not make any eye contact or stares; shows anger; laughs at/mocks patient; turned away from patient; repeatedly interrupts patient; ignores patient; answers mobile phone without permission
2	**DONE PARTIALLY**	= does not consistently use body language to express interest: rarely makes eye contact, shows limited emotion, appears artificial;
3	**DONE WELL**	= makes appropriate eye contact throughout interaction; smiles when appropriate; sits at appropriate angle from patient and leans in to show interest; use of 'uh-huh', 'hmm' and other keys to signal interest
2. VERBAL COMMUNICATION SKILLS: OPEN-ENDED QUESTIONS, SUMMARIZING, CLARIFYING STATEMENTS		
1	**NEED IMPROVEMENT**	= Uses mostly 'yes/no' questions, e.g. "will you? Can you?"
2	**DONE PARTIALLY**	= Uses open-ended questions, but does not explore topics further or summarize for patient to reflect upon
3	**DONE WELL**	= Open-ended questions, summarizes and clarifies statements, e.g., "What happened? Tell me more."
3. RAPPORT BUILDING & SELF-DISCLOSURE		
1	**NEED IMPROVEMENT**	= clinician does not introduce him/herself or attempt to make the patient feel comfortable **OR** clinician dominates the experience talking about his/her own experiences
2	**DONE PARTIALLY**	= clinician introduces him/herself but does not attempt to help the patient feel comfortable through small talk/informal conversation **OR** clinician disclosure but it is not related to patient experience or needs
3	**DONE WELL**	= clinician introduces self, tries to make patient feel comfortable **AND** disclosure focuses on patient needs
4. EXPLORATION, INTERPRETATION AND NORMALIZATION OF FEELINGS		
1	**NEED IMPROVEMENT**	= clinician does not ask about patient's feelings **OR** clinician is judgmental/critical about patient's emotions and feelings (e.g., "You shouldn't feel that way" "You should stop thinking or feeling that."
2	**DONE PARTIALLY**	= clinician asks but does not normalize/validate **OR** does not explore feelings in detail with patient (Yes/No)
3	**DONE WELL**	= clinician explains that the patient's feelings are common and expected for a person in his/her situation
5. EMPATHY, WARMTH, & GENUINENESS		
1	**NEED IMPROVEMENT**	= is critical, hostile, or dismissive of patient's concerns or complaints
2	**DONE PARTIALLY**	= clinician is generally warm and friendly to patient, but does not demonstrate the ability to put him/herself in the experience of the patient
3	**DONE WELL**	= clinician demonstrates that he/she understands the experience of patient in genuine, sincere manner
6. ASSESSING FUNCTIONING AND IMPACT ON LIFE		

1	**NEED IMPROVEMENT**	= clinician does not ask patient about the impact on functioning and daily life from feelings, thoughts, psychosocial problem, etc.
2	**DONE PARTIALLY**	= clinician asks functioning and daily life activities, but does NOT connect it to psychosocial/mental health concerns
3	**DONE WELL**	= clinician explores the relationship between psychosocial problem and functioning
7. EXPLORES PATIENT'S AND SOCIAL SUPPORT NETWORK'S EXPLANATION FOR PROBLEM (CASUAL MODEL)		
1	**NEED IMPROVEMENT**	= clinician does not ask patient about his/her own view of the cause OR is judgmental/critical about patient's explanation (e.g. "Witchcraft doesn't cause these problems, that is an ignorant/backwards idea!)
2	**DONE PARTIALLY**	= clinician asks patient about his/her own view of cause, but does not explore if this same as family
3	**DONE WELL**	= clinician asks patient about cause **and** asks if family/support network have same or different explanations
8. ASSESSING COPING MECHANISM AND PRIOR SOLUTIONS		
1	**NEED IMPROVEMENT**	= clinician does not ask patient about how patient has coped **OR** clinician is judgmental about how patient has coped (e.g., "Why did you think that work?" or "That isn't helpful.")
2	**DONE PARTIALLY**	= clinician asks about coping and prior solutions, but does not provide positive feedback
3	**DONE WELL**	= clinician asks about coping and provides positive feedback in regard to agency or pathways thinking
9. ASSESSING PATIENT'S RECENT LIFE EVENTS AND ACKNOWLEDGE IMPACT ON PSYCHOSOCIAL WELLBEING		
1	**NEED IMPROVEMENT**	= clinician does not ask about triggering life events
2	**DONE PARTIALLY**	= clinician asks about life events but does not connect with current mental health issues
3	**DONE WELL**	= clinician asks about life events and discusses connection with current mental health
10. OTHER MENTAL HEALTH, ALCOHOL/DRUGS, PHYSICAL HEALTH ISSUES		
1	**NEED IMPROVEMENT**	= clinician does not ask about any related conditions, e.g., alcohol or drug use, physical health issues, injuries, head trauma, medications, etc.
2	**DONE PARTIALLY**	= clinician takes partial history but does not explore positive responses
3	**DONE WELL**	= clinician assesses related health issues and explains relationship to patient's condition when appropriate
11. APPROPRIATE INVOLVEMENT OF FAMILY MEMBER, SIGNIFICANT OTHER, CAREGIVER		
1	**NEED IMPROVEMENT**	= clinician does not involve family orask about involvement of family in therapy **OR** clinician only talks to or about family members and ignores patient perspective, (e.g., "You should listen to your family more.)
2	**DONE PARTIALLY**	= clinician ask about family involvement, but does not explore patient's reasons for involvement or non-involvement
3	**DONE WELL**	= clinician helps both patient and family participate **and** encourages interaction between the two
12. COLLABORATIVE GOALS SETTING AND EXPECTATIONS OF THE PATIENT		

1	**NEED IMPROVEMENT**	= clinician does not ask patient about his/her goals and expectations for treatment **OR** clinician just tells patient what to do without asking his/her expectations
2	**DONE PARTIALLY**	= clinician asks patient about goals but does not discuss if these are realistic or can be accomplished
3	**DONE WELL**	= clinician asks about goals and discusses with patient what is and is not achievable through treatment; collaboratively clinician and patient establish treatment plan
13. CLINICIAN'S PROMOTION OF REALISTIC HOPE FOR CHANGE		
1	**NEED IMPROVEMENT**	= clinician either gives no hope (e.g. you will never get better) or gives unrealistic expectations (e.g. you will be cured in a few weeks and never have problems again) for what to expect in treatment and recovery
2	**DONE PARTIALLY**	= clinician vaguely tells patient what will happen during treatment
3	**DONE WELL**	= clinician helps patient feel positive about the future **and** creates realistic expectations about what can and cannot be achieved through treatment and explains treatment checking patient understanding
14. PSYCHOEDUCATION & EXPLAINING TREATMENT /PSYCHOSOCIAL SUPPORT IN LOCAL (ETHNOPSYCHOLOGICAL) TERMS		
1	**NEED IMPROVEMENT**	= clinician uses technical jargon to explain mental health **OR** uses stigmatizing terms **OR** does not explain how treatment works
2	**DONE PARTIALLY**	= clinician uses a limited amount of technical jargon but **No** stigmatizing terms
3	**DONE WELL**	= clinician conducts psychoeducation using local terminology and phrases to explain mental health and treatment in non-stigmatizing language, and checks to see if patient understands
15. PROBLEM SOLVING: PROBLEM FORMULATION & PRIORITIZATION, SOLUTION GENERATION, ACTION PLANNING		
1	**NEED IMPROVEMENT**	= clinician does work with patient to formulate key problem requiring help, support, or treatment
2	**DONE PARTIALLY**	= clinician helps patient formulate & prioritize key problem, but does not complete steps #2-4 (see below)
3	**DONE WELL**	=clinician helps patient (1) formulate and prioritize primary problem, (2) brainstorm solutions, (3) explores advantages and disadvantages, and (4) formulate action plan
16. ELICITING FEEDBACK AND PROVIDING ADVICE, SUGGESTIONS AND RECOMMENDATIONS		
1	**NEED IMPROVEMENT**	= clinician lectures patient what to do without asking if this is acceptable and comfortable to patient, **OR** clinician does not give any suggestions at all
2	**DONE PARTIALLY**	= clinician gives focused advice but does not ask for feedback from patient to see if the advice is helpful
3	**DONE WELL**	= clinician gives a few suggestions when asked by patient andasks for feedback about suggestions
17. CLINICIAN EXPLAINS CONFIDENTIALITY		
1	**NEED IMPROVEMENT**	= clinician does not address confidentiality OR does not adjust to setting
2	**DONE PARTIALLY**	= clinician tells patient thateverything is confidential with explaining harm to self or others
3	**DONE WELL**	= clinician explains that all clinician-patient discussions are confidential with the exception of harm to self and others AND adjust conversation to setting
18. HARM TO SELF, HARM TO OTHERS, AND HARM FROM OTHERS AND COLLABORATIVE RESPONSE PLAN		
1	**NEED IMPROVEMENT**	= clinician does not ask about harm to self or others
2	**DONE PARTIALLY**	= clinician asks about harm to self or others, but does not help patient develop a plan for safety
3	**DONE WELL**	= clinician asks about harm to self or others and facilitates appropriate actions to assure safety

ENACT-Self/Peer version

Date ___ ___ / ___ ___ / ___ ___ ___ ___ **Check One:** ☐ **Pre-Test** ☐ **Post-Test**
Day Month Year

Name: _____ Age: _____ Gender: M/FHealth profession: _____

Person completing form: _____

Location:_____

1. NON-VERBAL COMMUNICATION & ACTIVE LISTENING: EYE CONTACT, EXPRESSION, BODY LANGUAGE, & GESTURES ☐ **Not applicable**		
1	**NEEDS IMPROVEMENT**	= does not make any eye contact or stares; shows anger; laughs at/mocks patient; turned away from patient; repeatedly interrupts patient; ignores patient; answers mobile phone without permission
2	**DONE PARTIALLY**	= does not consistently use body language to express interest: rarely makes eye contact, shows limited emotion, appears artificial;
3	**DONE WELL**	= makes appropriate eye contact throughout interaction; smiles when appropriate; sits at appropriate angle from patient and leans in to show interest; use of 'uh-huh', 'hmm' and other keys to signal interest
2. VERBAL COMMUNICATION SKILLS: OPEN-ENDED QUESTIONS, SUMMARIZING, CLARIFYING STATEMENTS ☐ **Not applicable**		
1	**NEEDS IMPROVEMENT**	= Uses mostly 'yes/no' questions, e.g. "will you? Can you?"
2	**DONE PARTIALLY**	= Uses open-ended questions, but does not explore topics further or summarize for patient to reflect upon
3	**DONE WELL**	= Open-ended questions, summarizes and clarifies statements, e.g., "What happened? Tell me more."
3. RAPPORT BUILDING & SELF-DISCLOSURE ☐ **Not applicable**		
1	**NEEDS IMPROVEMENT**	= clinician does not introduce him/herself or attempt to make the patient feel comfortable **OR** clinician dominates the experience talking about his/her own experiences
2	**DONE PARTIALLY**	= clinician introduces him/herself but does not attempt to help the patient feel comfortable through small talk/informal conversation **OR** clinician disclosure but it is not related to patient experience or needs
3	**DONE WELL**	= clinician introduces self, tries to make patient feel comfortable **AND** disclosure focuses on patient needs
4. EXPLORATION, INTERPRETATION AND NORMALIZATION OF FEELINGS ☐ **Not applicable**		
1	**NEEDS IMPROVEMENT**	= clinician does not ask about patient's feelings **OR** clinician is judgmental/critical about patient's emotions and feelings (e.g., "You shouldn't feel that way" "You should stop thinking or feeling that."
2	**DONE PARTIALLY**	= clinician asks but does not normalize/validate **OR** does not explore feelings in detail with patient (Yes/No)
3	**DONE WELL**	= clinician explains that the patient's feelings are common and expected for a person in his/her situation
5. ASSESSING PATIENT'S RECENT LIFE EVENTS AND ACKNOWLEDGE IMPACT ON PSYCHOSOCIAL WELLBEING ☐ **Not applicable**		

1	**NEEDS IMPROVEMENT**	= clinician does not ask about triggering life events
2	**DONE PARTIALLY**	= clinician asks about life events but does not connect with current mental health issues
3	**DONE WELL**	= clinician asks about life events and discusses connection with current mental health
6. OTHER MENTAL HEALTH, ALCOHOL/DRUGS, PHYSICAL HEALTH ISSUES ☐ **Not applicable**		
1	**NEEDS IMPROVEMENT**	= clinician does not ask about any related conditions, e.g., alcohol or drug use, physical health issues, injuries, head trauma, medications, etc.
2	**DONE PARTIALLY**	= clinician takes partial history but does not explore positive responses
3	**DONE WELL**	= clinician assesses related health issues and explains relationship to patient's condition when appropriate
7. APPROPRIATE INVOLVEMENT OF FAMILY MEMBER, SIGNIFICANT OTHER, CAREGIVER ☐ **Not applicable**		
1	**NEEDS IMPROVEMENT**	= clinician does not involve family orask about involvement of family in therapy **OR** clinician only talks to or about family members and ignores patient perspective, (e.g., "You should listen to your family more.)
2	**DONE PARTIALLY**	= clinician ask about family involvement, but does not explore patient's reasons for involvement or non-involvement
3	**DONE WELL**	= clinician helps both patient and family participate **and** encourages interaction between the two
8. COLLABORATIVE GOALS SETTING AND EXPECTATIONS OF THE PATIENT ☐ **Not applicable**		
1	**NEEDS IMPROVEMENT**	= clinician does not ask patient about his/her goals and expectations for treatment **OR** clinician just tells patient what to do without asking his/her expectations
2	**DONE PARTIALLY**	= clinician asks patient about goals but does not discuss if these are realistic or can be accomplished
3	**DONE WELL**	= clinician asks about goals and discusses with patient what is and is not achievable through treatment; collaboratively clinician and patient establish treatment plan
9. PSYCHOEDUCATION & EXPLAINING TREATMENT /PSYCHOSOCIAL SUPPORT IN LOCAL (ETHNOPSYCHOLOGICAL) TERMS ☐ **Not applicable**		
1	**NEEDS IMPROVEMENT**	= clinician uses technical jargon to explain mental health **OR** uses stigmatizing terms **OR** does not explain how treatment works
2	**DONE PARTIALLY**	= clinician uses a limited amount of technical jargon but **No** stigmatizing terms
3	**DONE WELL**	= clinician conducts psychoeducation using local terminology and phrases to explain mental health and treatment in non-stigmatizing language, and checks to see if patient understands
10. ELICITING FEEDBACK AND PROVIDING ADVICE, SUGGESTIONS AND RECOMMENDATIONS ☐ **Not applicable**		

1	**NEEDS IMPROVEMENT**	= clinician lectures patient what to do without asking if this is acceptable and comfortable to patient, **OR** clinician does not give any suggestions at all
2	**DONE PARTIALLY**	= clinician gives focused advice but does not ask for feedback from patient to see if the advice is helpful
3	**DONE WELL**	= clinician gives a few suggestions when asked by patient andasks for feedback about suggestions

11. HARM TO SELF, HARM TO OTHERS, AND HARM FROM OTHERS AND COLLABORATIVE RESPONSE PLAN

☐ **Not applicable**

1	**NEEDS IMPROVEMENT**	= clinician does not ask about harm to self or others
2	**DONE PARTIALLY**	= clinician asks about harm to self or others, but does not help patient develop a plan for safety
3	**DONE WELL**	= clinician asks about harm to self or others and facilitates appropriate actions to assure safety

ANNEX 3: NAME LIST OF TRAINED PRESCRIBERS

Dolakha District

SN	Name	Designation	Health Institution
1	Dr. Shraddha Achrya	M.O.	PHC Charikot
2	Dr. Archana K.C	M.O.	Jiri Hospital
3	Sanjay K. Chaudhary	A.H.W.	HP Dandakharka
4	Bidyanand Chaudhary	A.H.W.	HP Thulopatal
5	SurendraPdNeupane	Sr. A.H.W.	HP Bhirkot
6	Sunder Hari Shrestha	H.A.	HP SuspaKshemawati
7	Kamal MahatraChhetri	H.A.	HP Syama
8	Gita Shivakoti	A.H.W.	HP Sunkhani
9	Kamala Moktan	A.H.W.	HP Laduk
10	Manoj Kumar Sing	A.H.W.	HP Bulung
11	KatakBdrGhising	A.H.W.	HP Bhusafeda
12	Premchandra Prasad Jayswal	A.H.W.	HP Alampu
13	Man BdrBhudhathoki	Sr. A.H.W.	HP Makaibari
14	Ram Bahadur Yogi	Sr. A.H.W.	HP Melung
15	Mandas Shrestha	Sr. A.H.W.	HP Ghyangsukathokar
16	Moti Pd. Chaulagain	Sr. A.H.W.	HP Mati
17	Bam Bahadur Tamang	Sr. A.H.W.	HP Gairimudi
18	PrithaJirel	A.H.W.	HP Mali
19	Rajani Maya Shrestha	A.H.W.	HP Magapauwa
20	Anil Kumar Shrestha	A.H.W.	HP Hawa
21	RamkrishMaskey	Sr. A.H.W.	HP Dolakha
22	TulsiPd.Subedi	Sr. A.H.W.	HP Boch
23	Kapil Mani Neupane	Sr. A.H.W.	HP Powati
24	Uttam Kumar Koirala	FPO	DHO Dolakha
25	Dilip Yadav	A.H.W.	HP Jugu
26	Nabaraj Shrestha	A.H.W.	HP Lapilang
27	Babu Lal Lama	Sr. A.H.W.	HP Mirge
28	Raja Ram Karki	I.O.	DHO Dolakha
29	Bhoj Raj Joshi	H.A.	DHO Dolakha

Ramechhap District

SN	Name of participants	Designation	Name of health facilities
1	Om Prakash Shrestha	Sr.A.H.W.	HP Pakarbas
2	Krishna Bahadur Rai	A.H.W.	HP Nagdha
3	Dr.Bipin Kumar Yadav	M.O.	PHC Khimti
4	RamSharanPaudel	PHI	HP Deurali
5	Durga Raj Majhi	A.H.W.	HP Bamti
6	Sanjay Kumar Yadav	H.A.	HP Bethan
7	Sita Rai	A.H.W.	HP Doramba
8	UdayShankerJha	A.H.W.	HP Betali
9	Salina Mahat	H.A.	Tamakoshi Hospital
10	TulaisaGautam	A.H.W.	HP Pherpu
11	Dr.SambidaDhakal	M.O.	PHC Manthali
12	Prem Bahadur Karki	Sr.A.H.W.	HP Tilpung
13	Bhula Prasad Dhungel	A.H.W.	HP Lakhanpur
14	Suman Kumar Mandal	A.H.W.	HP Rakathum
15	Dhirendra Kumar Yadav	A.H.W.	HP Gothgaun
16	Krishna Bahadur Tamang	Sr.A.H.W.	HP Rampur
17	Dr. Kumar Thapa	M.O.	DHO Ramechhap
18	Santhosh Raj Baral	A.H.W.	HP Thosey
19	Shunil Rai Yadav	A.H.W.	HP Pinkhuri
20	Umanath Das	A.H.W.	HP Namadi
21	Dr.KamchiBekoju	M.O.	DHO Ramechhap
22	Dipendra Narayan Shrestha	Sr.A.H.W.	DHO Ramechhap
23	Ram Naresh Chaudhary	A.H.W.	HP Priti
24	Permod Kumar Chaudhary	A.H.W.	PHC Gelu